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2012 – 2013

SOUTH CAROLINA HEALTH PLAN

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SOUTH CAROLINA STATE HEALTH PLANNING COMMITTEE

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All correspondence should be addressed to:

State Health Planning Committee
Division of Planning & Certification of Need
2600 Bull Street
Columbia, SC 29201
Telephone: (803) 545-4200
Fax: (803) 545-4579

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CHAPTER I

INTRODUCTION

A. Legal Basis:

Section 44-7-180 of the South Carolina Code of Laws requires the Department of Health and Environmental Control, with the advice of the S.C. State Health Planning Committee, to prepare a State Health Plan for use in the administration of the Certificate of Need Program.

B. Purpose:

The South Carolina Health Plan outlines the need for medical facilities and services in the State. This document is used as one of the criteria for reviewing projects under the Certificate of Need Program.

C. Health Planning Committee:

This committee is composed of fourteen members. Twelve are appointed by the Governor with at least one member from each congressional district. Health care consumers, health care financiers, including business and insurance, and health care providers are equally represented, with one of the providers being a nursing home administrator. One member is appointed by the Chairman of the Board of Health and Environmental Control and the State Consumer Advocate is an ex-officio member. The State Health Planning Committee will review the South Carolina Health Plan and submit it to the Board of Health and Environmental Control for final revision and adoption.

D. Relationship With Other Agencies:

The Department has received consultation and advice from a number of State Agencies, including the Department of Mental Health, Department of Disabilities and Special Needs, Vocational Rehabilitation Department, Department of Social Services, Department of Alcohol and Other Drug Abuse Services, Continuum of Care for Emotionally Disturbed Children, and the Department of Health and Human Services, during the development of this plan including the collection and analysis of data. Other organizations affected under the program, such as the S.C. Hospital Association, the S.C. Home Care Association and the S.C. Health Care Association, have been consulted as the need arises. The Department wishes to express its appreciation for their assistance.

The Department is aware that the ultimate responsibility for administering this program cannot be shared with any individual or organization; however, it does recognize the valuable contributions that can be made by other interested organizations and individuals. For that reason it will be the policy to actively seek cooperation and guidance from anyone who wishes to comment on this plan.

E. Standards of Construction and Equipment:

Construction of health care facilities will comply with the Standards for Licensing as promulgated by the S.C. Department of Health and Environmental Control.

F. Standards for Maintenance and Operation:

Pursuant to the "State Certification of Need and Health Facility Licensure Act," the Division of Health Licensing within the Department of Health and Environmental Control (DHEC) is designated as the responsible agency for the administration and enforcement of basic standards for maintenance and operation of health care facilities and services in South Carolina.

G. State Certification of Need and Health Facility Licensure Act:

1. The purpose of the State Certification of Need and Health Facility Licensure Act, as amended, is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services that will best serve public needs, and ensure that high quality services are provided in health facilities in this State.

2. This law requires the:

   (a) issuance of a Certificate of Need prior to the undertaking of any project prescribed by this article;

   (b) adoption of procedures and criteria for submittal of an application and appropriate review prior to issuance of a Certificate of Need;

   (c) preparation and publication of a State Health Plan, with the advice of the health planning committee; and

   (d) licensure of facilities rendering medical, nursing and other health care.

3. An applicant desiring a Certificate of Need for a health-related facility or service or any specific or general information pertaining to the law or its application may contact the Bureau of Health Facilities and Services Development, DHEC, at their mailing address: 2600 Bull Street, Columbia, South Carolina, 29201. The telephone number is (803) 545-4200; fax number is (803) 545-4579.

4. A copy of S.C. Department of Health and Environmental Control Regulation No. 61-15, Certification of Need for Health Facilities and Services, may be obtained from the above address, or accessed on the internet through www.scdhec.net.

H. Relative Importance of Project Review Criteria:

A general statement has been added to each section of Chapter II stating the project review criteria considered to be the most important in reviewing certificate of need applications for each type of facility, service, and equipment. These criteria are not listed in order of importance, but sequentially, as found in Chapter 8 of Regulation No. 61-15, Certification of Need for Health Facilities and Services. In addition, a finding has been made in each section as to whether the benefits of improved accessibility to each such type of facility, service and equipment may outweigh the adverse effects caused by the duplication of any existing facility, service or equipment.

I. Interpretation of the Plan:

The criteria and standards set forth in the Plan speak for themselves, and each section of the Plan must be read as a whole.

J. Quality of Patient Care:

There is both local and national interest regarding the quality of care in the delivery of health care services. The Department of Health and Environmental Control shares these concerns. Organizations such as the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC) and the Leapfrog Group have focused attention upon both patient safety and outcomes. These include the reduction of medical errors, decreasing the risk of health care-acquired infections, and the following of best practices for patient care.

During the development of this Plan, staff has reviewed the availability of data and quality standards for the types of beds and services referenced in the Plan. To the extent practicable, we have addressed quality standards in those sections of the Plan where we were comfortable that they were appropriate. However, we were not always able to identify standards that could be considered directly applicable for a bed or service in the Plan.

Therefore, where no standards are listed, an applicant may be requested to provide data from sources such as mySChospitals.com, hospitalcompare.hhs.gov, or leapfroggroup.org, to document how its quality of care compares to state, regional, or national averages.

K. Staffing Standards:

During the development of the 2008-2009 South Carolina Health Plan, the State Health Planning Committee agreed to undertake a study to determine how to incorporate nursing and technical staffing information into future Plans. Staff research indicates that California is the only state that mandates minimum nurse to patient ratios by law. Connecticut, Illinois, Nevada, Ohio, Oregon, Texas, and Washington require hospitals to establish committees to address staffing planning and policy. Several of these states require that at least 50% of the membership must be direct care RNs. There are also 5 states (Illinois, New Jersey, New York, Rhode Island, and Vermont) that require some form of public notification or posting of staffing levels. These are all approaches that can be discussed for South Carolina.

Staff participated on the Steering Committee for the Office of Healthcare Workforce Research for Nursing (OHWRN), which was attempting to develop a supply/demand forecast model for nurses and allied technical staff. However, that research project was not completed.

Staff amended the Joint Annual Report (JAR) formats to obtain the current number and type of staff (RNs, EKG Techs, Physical Therapists, etc) by sector (hospitals, nursing homes, ASFs, etc) and the number of hours they work annually. From this information, staff can develop comparative staffing data for different types of facilities. However, we do not have reliable staffing requirements that would be appropriate as CON standards in the Plan.

CHAPTER II

INVENTORY REGIONS AND FACILITY CATEGORIES

A. Inventory Regions and Service Areas:

This State Plan has adopted four regions and one statewide category for the purpose of inventorying health facilities and services as specified in Section C. below. These regions, based on existing geographic, trade and political areas, are a practical method of administration.

The need for hospital beds is based on the utilization of individual facilities. Nursing home and home health service needs are projected by county. The need for acute psychiatric services, alcohol and drug abuse services, comprehensive rehabilitation services, and residential treatment centers for children and adolescents is based on various service areas and utilization methodologies specified herein. Institutions serving a restricted population throughout the state are planned on a statewide basis. The need for most services (cardiac catheterization, open heart surgery, etc.) is based upon the service standard, which is a combination of utilization criteria and travel time requirements. Each service standard constitutes the service area for that particular service.

Any service area may cross multiple administrative, geographic, trade and/or political boundaries. Due to factors that may include availability, accessibility, personal or physician preferences, insurance and managed care contracts or coverage, or other reimbursement issues, patients may seek and receive treatment outside the county or inventory region in which they reside and/or outside of the state. Therefore, service areas may specifically cross inventory regions and/or state boundaries. The need for a service is analyzed by an assessment of existing resources and need in the relevant service area, along with other factors set forth in this Plan and applicable statutes and regulations.

B. Exceptions to Service Area Standards:

The health care delivery system is in a state of evolution both nationally and in South Carolina. Due to the health reform movement, a number of health care facilities are consolidating and establishing provider networks in order to better compete for contracts within the new environment. This is particularly important for the smaller, more rural facilities that run the risk of being bypassed by insurers and health care purchasers looking for the availability of comprehensive health care services for their subscribers.

Given the changing nature of the health care delivery system, affiliated hospitals may sometimes want to transfer or exchange specific technologies in order to better meet an identified need. Affiliated hospitals are defined as two or more health care facilities, whether inpatient or outpatient, owned, leased, sponsored, or who have a formal legal relationship with a central organization and whose relationship has been established for reasons other than for transferring beds, equipment or services. In certain instances such a transfer or exchange of acute services could be accomplished in a cost-effective manner and result in a more efficient allocation of health care resources. This transfer or exchange of services applies to both inpatient and outpatient services; however, such

transfers or exchanges could only occur between facilities within the same licensing category. A Certificate of Need would be required to achieve the transfer or exchange of services. In order to evaluate a proposal for the transfer or exchange of any health care technology reviewed under the Certificate of Need program, the following criteria must be applied to it:

(1) A transfer or exchange of services may be approved only if there is no overall increase in the number or amount of such services;

(2) Although such transfers may cross county or service area lines, the facilities must be located within the one-way driving time established for the proposed service of each other, as determined by the Department;

(3) The facility receiving the service must demonstrate the need for the additional capacity based on both historical and projected utilization patterns;

(4) The applicants must explain the impact of transferring the technology on the health care delivery system of the county and/or service area from which it is to be taken; any negative impact must be detailed, along with the perceived benefits of the proposal;

(5) The facility giving up the service may not use the loss of such services as justification for a subsequent request for the approval of establishment of such service;

(6) A written contract or agreement between the governing bodies of the affected facilities approving the transfer or exchange of services must be included in the Certificate of Need process;

(7) Each facility giving up a service must acknowledge in writing that this exchange is permanent; any further transfers would be subject to this same process.

C. Identification of Inventory Regions:

The inventory regions are designated as follows:

Region	Counties
I	Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, and Union.
II	Abbeville, Chester, Edgefield, Fairfield, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Richland, Saluda and York.
III	Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter and Williamsburg.
IV	Aiken, Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper and Orangeburg.

D. Estimated State Civilian Population:

Where these projections were required for calculations, this Plan has been developed using the estimated civilian population of 4,625,364 for 2010 and projected population of 4,958,900 for 2017. All population data (county, planning area, and statewide) were computed by the State Budget and Control Board, Division of Research and Statistical Services, in cooperation with the U.S. Bureau of Census. The Governor has designated the above agency as the official source of all population data to be used by state agencies. Please note that these are preliminary projections because not all of the 2010 Census data have been released. These numbers will be adjusted and finalized as the data become available.

E. Patient Statistics:

Patient statistics in the Plan are based on the 2010 Fiscal Year for health care facilities.

F. Facility Information and Plan Cut-Off Date:

Only those facilities reviewed under the Certificate of Need program are included in the inventory. The cut-off date for inclusion of information in this Plan was June 1, 2012.

CHAPTER III

ACUTE CARE HOSPITALS

A. General Hospitals:

1. Definitions:

"Hospital" means a facility organized and administered to provide overnight medical or surgical care or nursing care of illness, injury, or infirmity and may provide obstetrical care, and in which all diagnoses, treatment, or care is administered by or under the direction of persons currently licensed to practice medicine, surgery, or osteopathy.

"Hospital bed" means a bed for an adult or child patient. Bassinets for the newborn in a maternity unit nursery, beds in labor rooms, recovery rooms, and other beds used exclusively for emergency purposes are not included in this definition.

2. Availability:

There are three counties in South Carolina that do not have an existing or approved hospital: Lee, McCormick, and Saluda. Calhoun County is served by the Regional Medical Center of Orangeburg and Calhoun Counties. General hospital beds are available within approximately thirty (30) minutes travel time for the majority of the residents of the State, and current utilization and population growth are factored into the methodology for determining the need for general hospital beds.

3. Bed Capacity:

A. For existing beds, capacity is considered bed space designated exclusively for inpatient care, including space originally designed or remodeled for inpatient beds, even though temporarily not used for such purposes. The number of beds counted in any patient room is the maximum number for which adequate square footage is provided, except that single beds in single rooms have been counted even if the room contained inadequate square footage.

Adequate square footage is defined as:

100 square feet in single rooms;
80 square feet per bed or pediatric crib in multi-bed rooms;
40 square feet per bassinet in pediatric nurseries.

In measuring the square footage of patient rooms for the purpose of determining bed capacity, only the net usable space in the room was considered. Space in toilet rooms, washrooms, closets, vestibules, and corridors was not included.

B. For facilities constructed under the Certificate of Need program, bed capacity will be as stated in the certificate, regardless of oversize room construction.

C. For Areas Included:

1. Bed space in all nursing units, including: (1) intensive care unit and (2) minimal or self-care units.
2. Isolation units.
3. Pediatric units, including: (1) pediatric bassinets and (2) incubators located in the pediatric department.
4. Observation units equipped and staffed for overnight use.
5. All space designated for inpatient bed care, even if currently closed or assigned to easily convertible, non-patient uses such as administration offices or storage.
6. Space in areas originally designed as solaria, waiting rooms, offices, conference rooms and classrooms that have necessary fixed equipment and are accessible to a nurses station exclusively staffed for inpatient care.
7. Bed space under construction if planned for immediate completion (not an unfinished "shell" floor).

D. For Areas Excluded:

1. Newborn nurseries in maternity department.
2. Labor rooms.
3. Recovery rooms.
4. Emergency units.
5. Preparation or anesthesia induction rooms.
6. Rooms used for diagnostic or treatment procedures unless originally designed for patient care.
7. Hospital staff bed areas, including accommodations for on-call staff unless originally designed for patient care.
8. Corridors.
9. Solaria, waiting rooms and other areas that not permanently set aside, equipped and staffed exclusively for inpatient bed care.
10. Unfinished space (shell) [an area that is finished except for movable equipment shall not be considered unfinished space].
11. Psychiatric, substance abuse and comprehensive rehabilitation units of general hospitals are separate categories of bed utilizing the same criteria outlined for general acute beds.

4. Inventory:

A. All licensed general hospitals, including Federal facilities, are listed in the inventory. Patient days and admissions are as reported by the hospital. The number of patient days utilized for the general hospital bed need calculations does not include days of care rendered in licensed psychiatric units, substance abuse units, or comprehensive rehabilitation units of hospitals. These days of care are shown in the corresponding

inventories for each type of service. In addition, the days of care provided in Long-Term Care hospitals are not included in the general bed need calculations.

B. Total capacity by survey refers to a total designed capacity or maximum number of beds that may be accommodated as determined by an on-site survey. This capacity may exceed the number of beds actually set up and in use. It may also differ from the licensed capacity, which is based on State laws and regulations. Beds have been classified as conforming and nonconforming, according to standards of plant evaluation, such as:
   1. Fire-resistivity of each building.
   2. Fire and other safety factors of each building.
   3. Design and structural factors affecting the function of nursing units.
   4. Design and structural factors affecting the function of service departments.

5. Narrative: General Hospital Beds:

The General Acute Hospital bed need methodology uses the following variable occupancy rate factors:

0-174 bed hospitals, 65%;
175-349 bed hospitals, 70%; and
350+ bed hospitals, 75%.

The population and associated utilization are broken down by age groups. The use rates and projected average daily census are made for the age cohorts of 0-17, 18-64, and 65 and over, recognizing that different population groups have different hospital utilization rates. For some hospitals, different age groups were used based on the data provided by the facility.

Where the term "hospital bed need" is used, these figures are based upon utilization data for the general acute hospitals. This term does not suggest that facilities cannot operate at higher occupancy rates than used in the calculations without adding additional beds.

Certificate of Need Standards

1. Calculations of bed need are made for individual hospitals, because of the differing occupancy factors used for individual facilities, and then summed by county or service area to get the overall county/service area bed need.

2. The methodology for calculating bed need is as follows:

A. Determine the current facility use rate by dividing the current utilization by the current population in each of the three age cohorts.

B. Multiply the current facility use rate by age cohort by the projected population for seven years in the future by age cohort (in thousands) and divide by 365 to obtain a projected average daily census by age cohort.

C. Divide the sum of the age cohort projected facility average daily census by the variable occupancy (.65/.70/.75) to determine the number of beds needed to meet the hospital's need.

D. The number of additional beds needed or excess beds for the hospital is obtained by subtracting the number of existing beds from the bed need.

E. The totals for each hospital in a county or service area are summed to determine whether there is an overall projected surplus or need for additional beds.

3. If a county or service area indicates a surplus of beds, then no additional beds will be approved unless an individual hospital in the county/service area indicates a need for additional beds. Should an individual hospital indicate a need for additional beds, then a maximum of the actual projected bed need or up to 50 additional beds may be approved for that hospital to allow for the construction of an economical unit at either the existing hospital site or another site, if the existing hospital is relocating or has relocated in whole or in part to that site. The hospital requesting the addition must document the need for additional beds beyond those indicated as needed by the methodology stated above, based on historical and projected utilization, as well as projected population growth or other factors demonstrating the need for the proposed beds. Additional beds will only be approved for the specific hospital indicating a need.

4. If there is a need for additional hospital beds in the county or service area, then any entity may apply to add these beds within the county, and any entity may be awarded the Certificate of Need for these beds. If the number of beds needed is less than 50, then up to a total of 50 beds could be approved for any entity at any location within the county/service area. An applicant requesting additional beds beyond those indicated as needed by the methodology stated above, must document the need for additional beds based on historical and projected utilization, floor plan layouts, projected population growth that has not been considered in this Plan or other factors demonstrating the need for the proposed beds. It is up to the applicant to document the need and the potential negative impact on the existing facilities.

5. A facility may apply to create a new hospital at a different site (a "satellite hospital") within the same county or service area through the transfer of existing beds, the projected bed need for the facility, or a combination of both existing and projected beds. The facility is <u>not</u> required to have a projected need for additional beds in order to create a satellite hospital, and there is no required minimum number of beds in order to approve the CON application. The applicant must justify, through patient origin and other data, the reasons why such a facility is needed and the potential negative impacts it could have on the existing hospitals in the county or service area.

6. No additional hospitals will be approved unless they are a general hospital and will provide:

A. A 24-hour emergency services department, and meet the requirements to be a Level III emergency service as defined in Regulation 61-16 Sec. 613 Emergency Services.

B. Inpatient medical services to both surgical and non-surgical patients, and

C. Medical and surgical services on a daily basis within at least 6 of the major diagnostic categories as recognized by Centers for Medicare and Medicaid Services (CMS), as follows:

MDC 1: Diseases and disorders of the nervous system
MDC 2: Diseases and disorders of the eye
MDC 3: Diseases and disorders of the ear, nose, mouth and throat
MDC 4: Diseases and disorders of the respiratory system
MDC 5: Diseases and disorders of the circulatory system
MDC 6: Diseases and disorders of the digestive system
MDC 7: Diseases and disorders of the hepatobiliary system and pancreas
MDC 8: Diseases and disorders of the musculoskeletal system and connective tissue
MDC 9: Diseases and disorders of the skin, subcutaneous tissue and breast
MDC 10: Endocrine, nutritional and metabolic diseases and disorders
MDC 11: Diseases and disorders of the kidney and urinary tract
MDC 12: Diseases and disorders of the male reproductive system
MDC 13: Diseases and disorders of the female reproductive system
MDC 14: Pregnancy, childbirth and the puerperium
MDC 15: Newborns/other neonates with conditions originating in the prenatal period
MDC 16: Diseases and disorders of the blood and blood-forming organs and immunological disorders
MDC 17: Myeloproliferative diseases and disorders and poorly differentiated neoplasms
MDC 18: Infectious and parasitic diseases
MDC 19: Mental diseases and disorders
MDC20: Alcohol/drug use and alcohol/drug-induced organic mental disorders
MDC 21: Injury, poisoning and toxic effects of drugs
MDC 22: Burns
MDC 23: Factors influencing health status and other contact with health services
MDC 24: Multiple significant traumas
MDC 25: Human immunodeficiency virus infections

Any applicant for a new hospital must provide a written commitment that the facility will accept Medicare and Medicaid patients and that unreimbursed services for indigent and charity patients are provided at a percentage which meets or exceeds other hospitals in the county or service area.

7. Due to the low utilization and the low capital cost of converting hospital-based nursing home, psychiatric, rehabilitation and/or substance abuse beds to general acute care hospital beds, the following policies may apply:

A. Hospitals that have licensed nursing home beds within the hospital may be allowed to convert these nursing home beds to acute care hospital beds only within the hospital provided the hospital can document an actual need for these additional acute care beds. Need will be based on actual utilization, using current information. A CON is required for this conversion.

B. Existing general hospitals that have inpatient psychiatric, rehabilitation, or substance abuse beds may be allowed to convert these specialty beds to acute care hospital beds, regardless of the projected need for general acute care hospital beds, provided a Certificate of Need is received.

8. In some areas of South Carolina, a considerable influx of tourists is not counted in the permanent population. If an individual hospital in these areas can document and demonstrate the need for additional beds due to non-resident (tourist) population and seasonal utilization fluctuations due to this population, then, based on further analysis, the Department may approve some additional beds at the existing hospital.

9. Should a hospital request additional beds due to the deletion of services at a Federal facility that results in the immediate impact on the utilization of the hospital, then additional beds may be approved at the affected hospital. The impacted hospital must document this increase in demand and explain why additional beds are needed to accommodate the care of patients previously served at a Federal facility. Based on the analysis of utilization provided by the affected hospital, the Department may approve some additional hospital beds to accommodate this immediate need.

10. Changes in the delivery system due to health care reform have resulted in the consolidation of facilities and the establishment of provider networks. These consolidations and agreements may lead to situations where affiliated hospitals may wish to transfer beds between themselves in order to serve their patients in a more efficient manner. A proposal to transfer or exchange hospital beds requires a Certificate of Need and must comply with the following criteria:

A. A transfer or exchange of beds may be approved only if there is no overall increase in the number of beds;

B. Such transfers may cross county lines; however, the applicants must document with patient origin data the historical utilization of the receiving facility by residents of the county giving up beds;

C. Should the response to Criterion B fail to show a historical precedence of residents of the county transferring the beds utilizing the receiving facility, the applicants must document why it is in the best interest of these residents to transfer the beds to a facility with no historical affinity for them;

D. The applicants must explain the impact of transferring the beds on the health care delivery system of the county from which the beds are to be taken; any negative impact

must be detailed, along with the perceived benefits of such an agreement;

E. The facility receiving the beds must demonstrate the need for the additional capacity based on both historical and projected utilization patterns;

F. The facility giving up the beds may not use the loss of these beds as justification for a subsequent request for the approval of additional beds;

G. A written contract or agreement between the governing bodies of the affected facilities approving the transfer or exchange of beds must be included in the Certificate of Need application;

H. Each facility giving up beds must acknowledge in writing that this exchange is permanent; any further transfers would be subject to this same process.

11. Factors to be considered regarding modernization of facilities should include:

A. Functional arrangement of the facility as it relates to efficient handling of patients and related workloads.
B. The ability to update medical technology within the existing plant.
C. Existence of The Joint Commission (TJC) or other accreditation body deficiencies or "grandfathered" licensure deficiencies.
D. Cost efficiency of the existing physical plant versus plant revision, etc.
E. Private rooms are now considered the industry standard.

12. Each modernization proposal must be evaluated on the basis of merit, cost efficiency, and impact on health delivery and status within the service area.

The following pages depict the calculation of hospital bed need as described earlier.

Quality

CMS began implementing provisions of the Hospital Readmissions Reduction Program (part of the Patient Protection and Affordable Care Act) effective October 1, 2011. They will initially focus on readmission rates for heart attacks, heart failure, and pneumonia. Hospitals with excessive readmissions will face penalties of as much as 1% of their total Medicare billings for FY 2013, which will increase to 2% in FY 2014 and 3% in FY 2015.

A number of quality indicators have been identified for hospitals by organizations such as CMS (Hospital Compare), the Agency for Healthcare Research and Quality (AHRQ), and the Commonwealth Fund (Why Not the Best?). Data for these measures are accessible on-line, and it is possible to compare how hospitals rate on these various measures. They can also be compared against similar facilities (i.e. teaching hospitals) and against state and/or national averages.

Unfortunately, because each organization categorizes its data differently, these indicators can only be discussed in generalities. They can be roughly divided into four categories. The first measurements are what CMS calls Hospital Process of Care measures. These capture how often hospitals perform the recommended processes for different diagnoses. For example, do the hospitals give heart attack patients aspirin when they arrive at the hospital and smoking cessation advice/counseling before they're discharged? Are surgical patients receiving the right antibiotics prior to surgery to prevent infections or the right treatment to prevent blood clots? Source: http://www.hospitalcompare.hhs.gov/Hospital/Static/ConsumerInformation

The second type of indicator is what AHRQ calls Patient Safety Indicators (PSIs). These are indicators on potential preventable in-hospital adverse events and complications following surgery, childbirth, and other procedures. They include anesthesia complications, decubitus ulcers, leaving foreign bodies in after surgery, post-operative infections, transfusion reactions, and birth trauma. Source: http://www.qualityindicators.ahrq.gov/downloads/psi/2006-Feb-PatientSafetyIndicators.pdf

A sub-set of patient safety indicators is DHEC's Hospital Acquired Infections (HAI) report. It lists the actual and expected rates of Surgical Site Infections (SSIs) for various types of surgeries (coronary bypass, gallbladder removal, hysterectomy, knee replacement, etc.) and Central Line Associated Blood Stream Infection (CLABSI) rates for hospitals. Source: http://www.scdhec.gov/health/disease/hai/reports.htm

Next are Inpatient Quality Indicators (IQIs). These include volume (where there has been a link determined between the number of procedures performed and an outcome such as mortality), in-house mortality (examines outcomes following procedures and for common medical conditions), and utilization (where questions have been raised about over-use or under-use of a procedure). Examples include in-house mortality from hip replacements, GI hemorrhages, strokes, and pneumonia, and the volume of open heart surgeries and cesarean sections performed. Source: http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

The final indicator is Patient Satisfaction. A patient's perceptions of the care received during a hospital stay impacts how the patient views the outcome of the stay. The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey was developed by CMS and AHRQ to collect patient feedback. It asks whether nurses were readily available when called, procedures were adequately explained before they were performed, the room was kept clean, it was quiet at night, etc. As part of these surveys, patients rate their overall satisfaction with the facility (0-10) and whether they would recommend the hospital to others. Perceptions of poor patient care can hurt a hospital, even if the outcomes were satisfactory. Source: http://www.hospitalcompare.hhs.gov/Hospital/Static/ConsumerInformation

Hospitals should have high compliance rates for the procedures that have been identified as improving the quality of care or reducing the risks of complications. Infection rates should be below or comparable to the expected numbers.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Cost Containment; and
g. Adverse Effects on Other Facilities.

General hospital beds are located within approximately thirty (30) minutes travel time for the majority of the residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

2017 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2010 POP	2017 POP	2010 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
REGION I									
ANMED HEALTH MEDICAL CENTER	<18	44,825	45,900	619	2				
	18-64	113,972	119,200	35,087	101				
	+65	28,329	34,100	39,604	131				
	TOTAL	187,126	199,200	75,310	233	0.75	311	423	-112
ANMED WOMEN'S & CHILDRENS HOSPITAL	<18	44,825	45,900	126	0				
	18-64	113,972	119,200	7,153	20				
	+65	28,329	34,100	314	1				
	TOTAL	187,126	199,200	7,593	22	0.65	34	72	-38
ANDERSON COUNTY TOTAL							345	495	-150
UPSTATE CAROLINA MEDICAL CENTER	<18	13,654	14,200	607	2				
	18-64	34,246	36,400	6,871	20				
	+65	7,442	9,000	6,902	23				
	TOTAL	55,342	59,600	14,380	45	0.65	69	125	-56
CHEROKEE COUNTY TOTAL							69	125	-56
GREENVILLE MEMORIAL MEDICAL CENTER	<18	109,317	112,000	17,577	49				
	18-64	284,327	304,700	99,844	293				
	+65	57,581	70,200	49,895	167				
	TOTAL	451,225	486,900	167,316	509	0.75	679	746	-67
GREER MEMORIAL HOSPITAL	<18	109,317	112,000	217	1				
	18-64	284,327	304,700	7,164	21				
	+65	57,581	70,200	4,578	15				
	TOTAL	451,225	486,900	11,959	37	0.65	57	82	-25
HILLCREST MEMORIAL HOSPITAL	<18	109,317	112,000	8	0				
	18-64	284,327	304,700	4,125	12				
	+65	57,581	70,200	2,726	9				
	TOTAL	451,225	486,900	6,859	21	0.65	33	43	-10
PATEWOOD MEMORIAL HOSPITAL	<18	109,317	112,000	80	0				
	18-64	284,327	304,700	1,499	4				
	+65	57,581	70,200	1,135	4				
	TOTAL	451,225	486,900	2,714	8	0.65	13	72	-59
SAINT FRANCIS - DOWNTOWN & (SAINT FRANCIS MILLENNIUM) *1*	<18	109,317	112,000	378	1				
	18-64	284,327	304,700	27,014	79				
	+65	57,581	70,200	26,673	89				
	TOTAL	451,225	486,900	54,065	169	0.70	242	226	16
SAINT FRANCIS - EASTSIDE	<18	109,317	112,000	171	0				
	18-64	284,327	304,700	12,203	36				
	+65	57,581	70,200	4,791	16				
	TOTAL	451,225	486,900	17,165	52	0.65	80	93	-13
GREENVILLE COUNTY TOTAL							1,104	1,262	-158

2017 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2010 POP	2017 POP	2010 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
OCONEE MEMORIAL HOSPITAL	<18	15,707	16,000	591	2				
	18-64	44,460	46,700	16,743	48				
	+65	14,106	17,900	11,556	40				
	TOTAL	74,273	80,600	28,890	90	0.65	138	169	-31
OCONEE COUNTY TOTAL							**138**	**169**	**-31**
BAPTIST MEDICAL CENTER EASLEY	<18	24,287	25,600	240	1				
	18-64	78,944	84,900	7,249	21				
	+65	15,993	19,700	11,416	39				
	TOTAL	119,224	130,200	18,905	61	0.65	93	109	-16
CANNON MEMORIAL HOSPITAL	<18	24,287	25,600	15	0				
	18-64	78,944	84,900	1,527	5				
	+65	15,993	19,700	2,386	8				
	TOTAL	119,224	130,200	3,928	13	0.65	19	55	-36
PICKENS COUNTY TOTAL							**112**	**164**	**-52**
MARY BLACK MEMORIAL	<18	69,450	70,800	1,069	3				
	18-64	176,630	185,600	16,634	48				
	+65	38,227	46,900	9,469	32				
	TOTAL	284,307	303,300	27,172	83	0.70	118	174	-56
SPARTANBURG REG MED CTR	<18	69,450	70,800	3,200	9				
	18-64	176,630	185,600	66,566	192				
	+65	38,227	46,900	61,398	206				
	TOTAL	284,307	303,300	131,165	407	0.75	543	532	11
VILLAGE HEALTH CENTRE	<18	69,450	70,800	131	0				
	18-64	176,630	185,600	2,724	8				
	+65	38,227	46,900	2,512	8				
	TOTAL	284,307	303,300	5,367	17	0.75	22	48	-26
SPARTANBURG COUNTY TOTAL							**661**	**706**	**-45**
WALLACE THOMSON HOSPITAL	<18	6,600	6,500	279	1				
	18-64	17,592	16,800	4,151	11				
	+65	4,769	5,400	4,877	15				
	TOTAL	28,961	28,700	9,307	27	0.65	41	143	-102
UNION COUNTY TOTAL							**41**	**143**	**-102**
REGION II									
ABBEVILLE AREA MEDICAL CENTER	<18	5,787	5,900	75	0				
	18-64	15,427	15,700	996	3				
	+65	4,203	5,000	1,823	6				
	TOTAL	25,417	26,600	2,894	9	0.65	14	25	-11
ABBEVILLE COUNTY TOTAL							**14**	**25**	**-11**

2017 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2010 POP	2017 POP	2010 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CHESTER REGIONAL MEDICAL CENTER	<18	7,928	8,100	330	1				
	18-64	20,377	20,500	2,499	7				
	+65	4,835	5,800	2,893	10				
	TOTAL	33,140	34,400	5,722	17	0.65	27	82	-55
CHESTER COUNTY TOTAL							27	82	-55
EDGEFIELD COUNTY HOSPITAL	<18	5,771	5,800	15	0				
	18-64	17,690	19,000	270	1				
	+65	3,524	5,000	933	4				
	TOTAL	26,985	29,800	1,218	4	0.65	7	25	-18
EDGEFIELD COUNTY TOTAL							7	25	-18
FAIRFIELD MEMORIAL HOSPITAL	<18	5,431	5,500	45	0				
	18-64	14,960	14,900	1,448	4				
	+65	3,565	4,800	1,523	6				
	TOTAL	23,956	25,200	3,016	10	0.65	15	25	-10
FAIRFIELD COUNTY TOTAL							15	25	-10
SELF REGIONAL HEALTHCARE	<18	16,507	16,900	1,565	4				
	18-64	42,610	44,100	25,294	72				
	+65	10,544	12,200	24,504	78				
	TOTAL	69,661	73,200	51,363	154	0.75	205	354	-149
GREENWOOD COUNTY TOTAL							205	354	-149
KERSHAW HEALTH	<18	15,139	15,800	957	3				
	18-64	37,761	40,100	10,115	29				
	+65	8,797	11,100	12,841	44				
	TOTAL	61,697	67,000	23,913	77	0.65	118	121	-3
KERSHAW COUNTY TOTAL							118	121	-3
SPRINGS MEMORIAL HOSPITAL	<18	17,831	17,900	1,394	4				
	18-64	47,084	48,200	17,695	50				
	+65	11,737	14,500	12,760	43				
	TOTAL	76,652	80,600	31,849	97	0.70	138	199	-61
LANCASTER COUNTY TOTAL							138	199	-61
LAURENS COUNTY HOSPITAL	<18	15,427	15,500	238	1				
	18-64	41,122	44,000	5,652	17				
	+65	9,988	12,300	6,009	20				
	TOTAL	66,537	71,800	11,899	37	0.65	58	76	-18
LAURENS COUNTY TOTAL							58	76	-18
LEXINGTON MEDICAL CENTER	<18	45,519	46,763	1,051	3				
	18-64	120,765	130,633	48,158	143				
	+65	22,222	29,095	40,884	147				
	TOTAL	188,506	206,491	90,093	292	0.75	390	414	-24
LEXINGTON COUNTY TOTAL							390	414	-24

2017 HOSPITAL BED NEED

FACILITY/COUNTY		AGE CAT	2010 POP	2017 POP	2010 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
NEWBERRY COUNTY MEMORIAL		<18	8,544	8,700	299	1				
		18-64	23,005	23,200	3,578	10				
		+65	5,959	7,400	4,232	14				
		TOTAL	37,508	39,300	8,109	25	0.65	39	90	-51
NEWBERRY COUNTY TOTAL								39	90	-51
PALMETTO HEALTH BAPTIST & PALMETTO HEALTH PARKRIDGE	*2*	<18	106,196	109,682	900	3				
		18-64	304,763	317,868	51,036	146				
		+65	47,430	62,005	17,214	62				
		TOTAL	458,389	489,555	69,150	210	0.75	280	363	-83
PALMETTO HEALTH RICHLAND		<18	106,196	109,682	25,339	72				
		18-64	304,763	317,868	100,124	286				
		+65	47,430	62,005	45,253	162				
		TOTAL	458,389	489,555	170,716	520	0.75	693	579	114
PROVIDENCE HOSPITAL		<18	106,196	109,682	287	1				
		18-64	304,763	317,868	20,808	59				
		+65	47,430	62,005	31,114	111				
		TOTAL	458,389	489,555	52,209	172	0.70	245	258	-13
PROVIDENCE HOSPITAL NORTHEAST		<18	106,196	109,682	91	0				
		18-64	304,763	317,868	6,622	19				
		+65	47,430	62,005	3,843	14				
		TOTAL	458,389	489,555	10,556	33	0.65	51	84	-33
RICHLAND COUNTY TOTAL								1,269	1,284	-15
PIEDMONT MEDICAL CENTER		<18	57,744	59,300	1,308	4				
		18-64	142,703	158,000	28,217	86				
		+65	25,626	33,300	27,198	97				
		TOTAL	226,073	250,600	56,723	186	0.70	266	268	-2
CAROLINAS MED CTR - FORT MILL	*3*	<18	57,744	59,300						
		18-64	142,703	158,000						
		+65	25,626	33,300						
		TOTAL	226,073	250,600			0.65		64	
YORK COUNTY TOTAL					56,723	186		266	332	-2
REGION III										
CHESTERFIELD GENERAL HOSPITAL		<18	11,557	11,600	477	1				
		18-64	28,845	29,100	4,181	12				
		+65	6,332	7,900	4,493	15				
		TOTAL	46,734	48,600	9,151	27	0.65	41	59	-18
CHESTERFIELD COUNTY TOTAL								41	59	-18
CLARENDON MEMORIAL HOSPITAL		<18	7,800	7,750	348	1				
		18-64	20,800	20,410	6,779	18				
		+65	8,000	8,110	5,311	15				
		TOTAL	36,600	36,270	12,438	34	0.65	52	56	-4
CLARENDON COUNTY								52	56	-4

2017 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2010 POP	2017 POP	2010 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CAROLINA PINES REGIONAL	<18	16,658	16,200	1,537	4				
	18-64	42,230	42,100	13,863	38				
	+65	9,793	12,400	7,105	25				
	TOTAL	68,681	70,700	22,505	67	0.65	102	116	-14
MCLEOD MEDICAL CENTER - DARLINGTON	<18	16,658	16,200		0				
	18-64	42,230	42,100	591	2				
	+65	9,793	12,400	2,618	9				
	TOTAL	68,681	70,700	3,209	11	0.65	16	49	-33
DARLINGTON COUNTY TOTAL							118	165	-47
MCLEOD MEDICAL CENTER - DILLON	<18	8,574	8,300	762	2				
	18-64	19,329	18,900	7,161	19				
	+65	4,159	5,100	4,033	14				
	TOTAL	32,062	32,300	11,956	35	0.65	53	79	-26
DILLON COUNTY TOTAL							53	79	-26
CAROLINAS HOSPITAL SYSTEM	<18	33,700	34,100	1,796	5				
	18-64	85,168	86,000	37,180	103				
	+65	18,017	23,200	29,403	104				
	TOTAL	136,885	143,300	68,379	212	0.70	302	310	-8
WOMENS CTR CAROLINAS HOSP SYSTEM	<18	33,700	34,100	132	0				
	18-64	85,168	86,000	2,721	8				
	+65	18,017	23,200	0	0				
	TOTAL	136,885	143,300	2,853	8	0.65	12	20	-8
LAKE CITY COMMUNITY HOSPITAL	<18	33,700	34,100	101	0				
	18-64	85,168	86,000	1,834	5				
	+65	18,017	23,200	1,311	5				
	TOTAL	136,885	143,300	3,246	9	0.65	14	48	-34
MCLEOD REGIONAL MEDICAL CENTER	<18	33,700	34,100	7,681	21				
	18-64	85,168	86,000	60,419	167				
	+65	18,017	23,200	48,395	171				
	TOTAL	136,885	143,300	116,495	359	0.75	479	453	26
FLORENCE COUNTY TOTAL							807	831	-24
GEORGETOWN MEMORIAL HOSPITAL	<18	13,020	12,400	852	2				
	18-64	35,218	35,600	8,601	24				
	+65	11,920	16,900	16,428	64				
	TOTAL	60,158	64,900	25,881	90	0.65	138	131	7
WACCAMAW COMMUNITY HOSPITAL	<18	13,020	12,400	450	1				
	18-64	35,218	35,600	9,484	26				
	+65	11,920	16,900	16,278	63				
	TOTAL	60,158	64,900	26,212	91	0.65	139	124	15
GEORGETOWN COUNTY TOTAL							277	255	22

2017 HOSPITAL BED NEED

FACILITY/COUNTY		AGE CAT	2010 POP	2017 POP	2010 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CONWAY HOSPITAL		<18	54,242	55,100	1,102	3				
		18-64	168,979	187,200	18,140	55				
		+65	46,070	62,400	15,092	56				
		TOTAL	269,291	304,700	34,334	114	0.70	164	210	-46
GRAND STRAND REGIONAL MEDICAL CTR		<18	54,242	55,100	1,033	3				
		18-64	168,979	187,200	26,126	79				
		+65	46,070	62,400	34,149	127				
		TOTAL	269,291	304,700	61,308	209	0.70	298	269	29
LORIS COMMUNITY HOSPITAL & SEACOAST MEDICAL CENTER	*4*	<18	54,242	55,100	539	2				
		18-64	168,979	187,200	6,824	21				
		+65	46,070	62,400	7,726	29				
		TOTAL	269,291	304,700	15,089	51	0.65	78	155	-77
HORRY COUNTY TOTAL								**540**	**634**	**-94**
MARION REGIONAL HOSPITAL	*5*	<18	8,071	7,800	0	0				
		18-64	20,139	19,800	0	0				
		+65	4,852	6,300	0	0				
		TOTAL	33,062	33,900	0	0	0.65	0	124	-124
MARION COUNTY TOTAL								**0**	**124**	**-124**
MARLBORO PARK HOSPITAL		<18	6,323	6,100	283	1				
		18-64	18,831	17,500	2,790	7				
		+65	3,779	4,400	1,884	6				
		TOTAL	28,933	28,000	4,957	14	0.65	21	94	-73
MARLBORO COUNTY TOTAL								**21**	**94**	**-73**
TUOMEY		<18	27,431	28,300	3,572	10				
		18-64	66,104	67,200	35,212	98				
		+65	13,921	17,300	26,619	91				
		TOTAL	107,456	112,800	65,403	199	0.70	284	283	1
SUMTER COUNTY TOTAL								**284**	**283**	**1**
WILLIAMSBURG REGIONAL HOSPITAL		<18	8,122	7,600	20	0				
		18-64	21,262	20,000	1,156	3				
		+65	5,039	6,500	2,291	8				
		TOTAL	34,423	34,100	3,467	11	0.65	17	25	-8
WILLIAMSBURG COUNTY TOTAL								**17**	**25**	**-8**
REGION IV										
AIKEN REGIONAL MEDICAL CENTER		<18	36,828	37,400	455	1				
		18-64	98,652	105,600	19,667	58				
		+65	24,619	31,300	21,127	74				
		TOTAL	160,099	174,300	41,249	133	0.70	189	183	6
AIKEN COUNTY TOTAL								**189**	**183**	**6**

2017 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2010 POP	2017 POP	2010 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
ALLENDALE COUNTY HOSPITAL	<18	2,326	2,300	17	0				
	18-64	6,718	6,400	318	1				
	+65	1,375	1,800	607	2				
	TOTAL	10,419	10,500	942	3	0.65	5	25	-20
ALLENDALE COUNTY TOTAL							5	25	-20
(BAMBERG COUNTY MEMORIAL) *6*	<18	9,371	9,000	35	0				
	18-64	23,499	23,100	900	2				
	+65	5,738	7,300	3,479	12				
	TOTAL	38,608	39,400	4,414	15	0.65	23	59	-36
BARNWELL COUNTY HOSPITAL	<18	9,371	9,000	125	0				
	18-64	23,499	23,100	1,343	4				
	+65	5,738	7,300	1,341	5				
	TOTAL	38,608	39,400	2,809	9	0.65	13	53	-40
BAMBERG/BARNWELL SERVICE AREA TOTAL							36	112	-76
BEAUFORT MEMORIAL HOSPITAL	<18	34,348	32,700	1,345	4				
	18-64	94,853	102,100	18,637	55				
	+65	33,032	47,800	17,297	69				
	TOTAL	162,233	182,600	37,279	127	0.65	196	169	27
HILTON HEAD HOSPITAL	<18	34,348	32,700	204	1				
	18-64	94,853	102,100	6,738	20				
	+65	33,032	47,800	11,334	45				
	TOTAL	162,233	182,600	18,276	65	0.65	101	93	8
BEAUFORT COUNTY TOTAL							297	262	35
TRIDENT MED CENTER & BERKELEY *7* MEDICAL CENTER	<18	154,646	160,800	1,324	4				
	18-64	433,597	439,600	34,014	94				
	+65	76,364	103,900	34,778	130				
	TOTAL	664,607	704,300	70,116	228	0.70	326	346	-20
SUMMERVILLE MEDICAL CENTER	<18	154,646	160,800	479	1				
	18-64	433,597	439,600	12,313	34				
	+65	76,364	103,900	9,650	36				
	TOTAL	664,607	704,300	22,442	72	0.65	110	124	-14
MUSC MEDICAL CENTER	<18	154,646	160,800	28,490	81				
	18-64	433,597	439,600	93,633	260				
	+65	76,364	103,900	36,674	137				
	TOTAL	664,607	704,300	158,797	478	0.75	638	604	34
ROPER, ROPER ST FRANCIS MT PLEASANT & ROPER ST FRANCIS - BERKELEY *8*	<18	154,646	160,800	77	0				
	18-64	433,597	439,600	31,373	87				
	+65	76,364	103,900	41,307	154				
	TOTAL	664,607	704,300	72,757	241	0.75	322	401	-79
BON SECOURS ST FRANCIS XAVIER	<18	154,646	160,800	296	1				
	18-64	433,597	439,600	19,426	54				
	+65	76,364	103,900	12,887	48				
	TOTAL	664,607	704,300	32,609	103	0.70	147	204	-57

2017 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2010 POP	2017 POP	2010 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
EAST COOPER REGIONAL MEDICAL CTR	<18	154,646	160,800	91	0				
	18-64	433,597	439,600	9,810	27				
	+65	76,364	103,900	5,335	20				
	TOTAL	664,607	704,300	15,236	47	0.65	73	140	-67
BERKELEY/CHARLESTON/DORCHESTER TOTAL							1,616	1,819	-203
COLLETON MEDICAL CENTER	<18	9,492	9,800	490	1				
	18-64	23,322	23,700	10,736	30				
	+65	6,078	7,700	9,667	34				
	TOTAL	38,892	41,200	20,893	65	0.65	100	131	-31
COLLETON COUNTY TOTAL							100	131	-31
HAMPTON REGIONAL MEDICAL CTR	<18	5,091	5,100	37	0				
	18-64	13,170	13,400	1,554	4				
	+65	2,829	3,700	2,206	8				
	TOTAL	21,090	22,200	3,797	12	0.65	19	32	-13
HAMPTON COUNTY TOTAL							19	32	-13
COASTAL CAROLINA MED CTR	<18	6,141	5,900	30	0				
	18-64	15,867	17,400	1,791	5				
	+65	2,769	3,700	2,424	9				
	TOTAL	24,777	27,000	4,245	14	0.65	22	41	-19
JASPER COUNTY TOTAL							22	41	-19
REG MED CTR ORANGEBURG-CALHOUN	<18	24,734	24,895	2,017	6				
	18-64	66,738	67,000	24,056	66				
	+65	16,204	20,600	24,515	85				
	TOTAL	107,676	112,495	50,588	157	0.70	225	247	-22
ORANGEBURG/CALHOUN COUNTY TOTAL							225	247	-22

1 ST. FRANCIS MILLINIUM HOSPITAL CON APPROVED 6/12/09. CON VOIDED 8/1/11.
2 BED NEEDS COMBINED; NEW HOSPITAL CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED, CON ISSUED 6/8/10.
3 CON APPROVED 9/9/11; APPEALED.
4 BED NEEDS COMBINED;THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED; CON 9/4/07.
5 FACILITY DID NOT PROVIDE UTILIZATION DATA FOR 2010.
6 HOSPITAL CLOSED 4/30/12.
7 BED NEEDS COMBINED;THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BED NEED FROM THE EXISTING HOSPITAL; APPEALED.
8 BED NEEDS COMBINED; MT PLEASANT WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL 5/31/06. BERKELEY WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED.

HOSPITAL OCCUPANCY RATES

	2008	2009	2010
REGION I	**55.8**	**53.5**	**52.1**
ANMED HEALTH MEDICAL CENTER	50.4	49.2	48.8
ANMED HEALTH WOMEN'S & CHILDREN'S	33.7	30.5	28.9
UPSTATE CAROLINA MEDICAL CENTER	33.9	38.2	31.5
GREENVILLE MEMORIAL MEDICAL CTR	66.8	62.6	61.4
GREER MEMORIAL	48.1	55.1	40.0
HILLCREST MEMORIAL HOSPITAL	50.6	41.8	43.7
PATEWOOD MEMORIAL	10.7	11.1	10.3
SAINT FRANCIS - DOWNTOWN	77.7	71.4	65.5
SAINT FRANCIS - EASTSIDE	56.5	53.1	50.6
OCONEE MEMORIAL HOSPITAL	44.8	48.0	48.4
CANNON MEMORIAL HOSPITAL	18.7	18.1	19.6
BAPTIST MED CTR EASLEY	51.4	46.8	47.5
MARY BLACK MEMORIAL HOSPITAL	44.3	41.9	42.3
SPARTANBURG REGIONAL MEDICAL CTR	72.4	71.8	74.2
VILLAGE HEALTHCARE CENTRE	---	18.0	30.6
WALLACE THOMSON HOSPITAL	21.1	18.1	17.8
REGION II	**58.4**	**57.4**	**55.7**
ABBEVILLE AREA MEDICAL CENTER	36.3	28.0	31.7
CHESTER REGIONAL MEDICAL CENTER	24.4	23.3	19.1
EDGEFIELD COUNTY HOSPITAL	21.6	19.2	13.3
FAIRFIELD MEMORIAL HOSPITAL	34.5	32.0	33.1
SELF REGIONAL HEALTHCARE	43.2	42.8	39.8
KERSHAW HEALTH	61.8	60.5	54.1
SPRINGS MEMORIAL HOSPITAL	50.3	52.4	39.6
LAURENS COUNTY HOSPITAL	44.7	43.2	42.9
LEXINGTON MEDICAL CENTER	73.9	68.2	63.8
NEWBERRY COUNTY MEM HOSPITAL	32.7	30.5	24.7
PALMETTO HEALTH BAPTIST	51.8	53.4	52.2
PALMETTO HEALTH RICHLAND	75.4	78.1	80.8
PROVIDENCE HOSPITAL	58.6	55.4	55.4
PROVIDENCE HOSPITAL NORTHEAST	60.9	61.3	51.6
PIEDMONT MEDICAL CENTER	62.6	57.1	58.0

	2008	2009	2010
REGION III	**59.9**	**57.0**	**54.3**
CHESTERFIELD GENERAL HOSPITAL	52.3	47.8	42.5
CLARENDON MEMORIAL HOSPITAL	68.4	66.0	60.9
CAROLINA PINES REGIONAL MED CTR	72.7	71.0	53.2
MCLEOD MED CTR - DARLINGTON	49.4	12.3	17.9
MCLEOD MED CTR - DILLON	39.2	36.8	41.5
CAROLINAS HOSPITAL SYSTEM	61.5	53.5	60.4
LAKE CITY COMMUNITY HOSPITAL	22.8	24.7	18.5
MCLEOD REGIONAL MEDICAL CENTER	71.4	68.5	70.5
WOMEN'S CENTER CAROLINAS HOSP	49.6	47.7	39.1
GEORGETOWN MEMORIAL HOSPITAL	55.4	57.3	54.0
WACCAMAW COMMUNITY HOSPITAL	81.5	87.4	57.8
CONWAY HOSPITAL	63.9	61.3	58.8
GRAND STRAND REGIONAL MED CTR	72.7	72.0	76.7
LORIS COMMUNITY HOSPITAL	39.3	43.0	39.4
MARION REGIONAL HOSPITAL *1*	42.1	39.0	0.0
MARLBORO PARK HOSPITAL	15.4	12.3	14.4
TUOMEY	66.7	64.6	63.3
WILLIAMSBURG REGIONAL HOSPITAL	15.5	16.4	38.0
REGION IV	**57.1**	**56.7**	**55.7**
AIKEN REGIONAL MEDICAL CENTER	61.9	60.3	61.8
ALLENDALE COUNTY HOSPITAL	14.5	13.6	10.3
BAMBERG COUNTY MEMORIAL HOSP	9.7	14.2	20.5
BARNWELL COUNTY HOSPITAL	18.9	12.4	14.5
BEAUFORT MEMORIAL HOSPITAL	63.9	65.5	60.4
HILTON HEAD REGIONAL MEDICAL CTR	54.9	56.2	53.8
SUMMERVILLE MEDICAL CENTER	60.8	60.6	65.4
BON SECOURS ST FRANCIS XAVIER	50.4	47.5	43.8
CHARLESTON MEMORIAL HOSPITAL	26.8	---	---
EAST COOPER MEDICAL CENTER	49.3	46.5	33.8
MUSC MEDICAL CENTER	75.7	68.7	72.5
ROPER HOSPITAL	56.4	54.9	51.5
ROPER MOUNT PLEASANT HOSPITAL	---	---	12.3
TRIDENT MEDICAL CENTER	68.5	65.8	64.9
COLLETON MEDICAL CENTER	46.5	47.8	43.7
HAMPTON REGIONAL MEDICAL CENTER	12.3	31.9	32.5
COASTAL CAROLINA MEDICAL CENTER	33.6	33.6	37.5
REG MED CTR ORANGEBURG/CALHOUN	59.6	57.5	56.1

1 FACILITY FAILED TO PROVIDE 2010 DATA

B. Long-Term Acute Care Hospitals:

Long Term Acute Care Hospitals (LTACHs) are hospitals with an average Medicare inpatient length of stay of greater than 25 days, including all covered and non-covered days of stay of Medicare patients. The 25 day Medicaid ALOS requirement has been waived for some pilot programs. They provide treatment to patients with complex medical conditions, such as strokes, cardiac care, ventilator dependency, wound care and post-surgical care. Medicare pays for about 73% of all LTACH discharges; the standard federal reimbursement for 2011 was $37,405 per patient.

As of November 2010 there were 434 LTACHs nationwide, and they may be either a freestanding facility, or may occupy space in another hospital ("hospital-within-a-hospital"). Hospitals must meet additional Federal criteria in order to qualify as a LTACH Hospital under the "hospital-within-a-hospital" model:

1) The new hospital must have a governing body, which is distinct and separate from the governing body of the host hospital, and the new body cannot be under the control of the host hospital or any third entity that controls both hospitals.

2) The LTACH must have a separate Chief Executive Officer through whom all administrative authority flows, who is not employed by, or under contract with, the host hospital or any third entity that controls both hospitals.

3) The hospital must have a separate Chief Medical Officer who reports directly to the governing body and is responsible for all medical staff activities. The Chief Medical Officer cannot be under contract with the host hospital or any third entity that controls both hospitals.

4) The hospital must have a separate medical staff from the medical staff of the host hospital, which report directly to the governing body, and adopt bylaws governing medical care, including granting privileges to individual practitioners.

LTACHs have their own Prospective Payment System (PPS). In 2006, CMS established a "25% payment threshold policy" for LTACHs. For the current details of the policy consult 42 CFR 412.534(c)(1).

CMS had proposed revising the reimbursement policy and extending the 25% rule to all LTACHs; if any LTACH gets more than 25% of its admissions from a single hospital it will receive less reimbursement. However, under Health Reform, regulatory relief from the 25% rule and a moratorium on the development of new facilities was extended to 2012. The LTACH DRGs were re-weighted in 2009 and CMS provided a 2% payment increase for FY 2010.

The existing LTACHs in South Carolina and their occupancy rates are:

FACILITY	COUNTY	BEDS	2008	2009	2010
NORTH GREENVILLE LONG TERM ACUTE	GREENVILLE	45	58.0	62.3	54.4
REGENCY HOSPITAL OF GREENVILLE 1	GREENVILLE	32	74.2	71.6	---
SPARTANBURG HOSP RESTORATIVE CARE	SPARTANBURG	97	33.2	34.6	37.0
INTERMEDICAL HOSPITAL OF SC	RICHLAND	35	66.0	67.9	61.5
REGENCY HOSPITAL OF SOUTH CAROLINA	FLORENCE	40	73.7	77.0	85.4
PACE HEALTHCARE COMMONS *2*	BEAUFORT	32	---	---	---
KINDRED HOSPITAL CHARLESTON *3*	CHARLESTON	59	50.4	46.0	47.9
	TOTAL	340			

1 FACILITY FAILED TO PROVIDE UTILIZATION DATA FOR 2010.
2 CON ISSUED 9/22/11, SC-11-36.
3 CON ISSUED FOR REPLACEMENT HOSPITAL 6/3/11, SC-11-18.

Certificate of Need Standards

1. An application for a Long Term Acute Care Hospital must be in compliance with the relevant standards in Regulation No. 61-16, Licensing Standards for Hospital and Institutional General Infirmaries.

2. Although Long Term Acute Care Hospital beds are not considered to be a separate category for licensing purposes, they will be inventoried separately from general acute care hospital beds for planning purposes.

3. The utilization of LTACHs is not included in the bed need for general acute care hospital beds. No bed need will be calculated for Long Term Acute Care Hospital beds. An applicant must document the need for LTACH beds based on the utilization of existing LTACH beds.

4. A hospital that has leased general beds to a Long Term Acute Care Hospital shall be entitled to regain these beds once the lease is terminated. No entity other than the hospital that initially leased the general acute beds (or its successor) to the Long Term Acute Care Hospital shall be entitled to obtain the rights to the beds upon termination of the lease. A Certificate of Need application is required:

A. a hospital may be allowed to convert these former LTACH beds to general acute hospital beds regardless of the projected need for general acute beds;

B. a hospital may be allowed to convert these former LTACH beds to psychiatric, inpatient treatment facility, rehabilitation, or other specialty beds only if there is a bed need projected for this proposed other category of licensed beds.

5. A hospital which desires to be designated as an LTACH and has been awarded a CON for that purpose, must be certified as an LTACH by CMS within 24 months of accepting its first patient, or the CON issued to that hospital for that purpose shall be revoked. The entity that has had its CON revoked shall not have the authority to operate as a general acute care hospital.

Quality

The DHEC Hospital Acquired Infections (HAI) report includes a standardized Central Line Associated Blood Stream Infections (CLABSI) ratio for LTACHs. Each LTACH is compared to the national standard population of hospitals entering HAI data into the National Healthcare Safety Network (NHSN) database. The Standardized Infection Ratio (SIR) is a summary measure used to compare the CLABSI experience among a group of reported locations to that of a standard population. It is the observed number of infections divided by the expected (predicted) number of infections. For HAI reports, the standard population comes from NHSN data reported from all hospitals using the system in the United States. The "expected" number of infections is based on historical data for those procedures at the national level. All South Carolina LTACHs should be lower than, or not different from, their statistically expected ratios. The 2009-2010 report is accessible online at: http://www.scdhec.gov/health/disease/hai/docs/10/Table%206%20-%20CLABSI%20SIR%20Long%20Term%20Acute%20Care.pdf. The Department may use the HAI report in evaluating a CON application for additional LTACH beds at an existing facility.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Financial Feasibility.

Long Term Acute Care Hospital beds are located within approximately sixty (60) minutes travel time for the majority of the residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

C. Critical Access Hospitals:

Rural counties tend to have higher unemployment and a preponderance of low-paying jobs that do not provide health insurance; a greater percentage of their population is elderly. Rural hospitals are usually smaller than urban hospitals, with fewer physicians and other health care professionals, and diagnostic and therapeutic technology is generally less available. They typically have a high Medicare and Medicaid case mix, but receive lower reimbursement from Medicare than urban facilities. At the same time, many rural hospitals are the sole community provider and one of the major employers in the community. The loss of a rural hospital has a major impact on the delivery of health services for the citizens of a community.

CMS has several programs, such as the Medicare Rural Hospital Flexibility Program and the Frontier Community Health Integration Demonstration Program, that designate these hospitals for additional benefits. These include Medicare Dependent (fewer than 100 beds with more than 60% Medicare patients), Rural Referral Center (more than 275 beds), Sole Community Providers (geographically isolated, and Critical Access Hospitals (CAHs). Hospitals can qualify for more than one of these designations and they have varying financial benefits.

Critical Access Hospitals are eligible for reimbursement at 101% of costs without having to meet all criteria for full-service acute care hospitals. They are intended to provide essential health services to rural communities; converting a struggling rural hospital to a CAH can allow a community to maintain local health access that would otherwise be lost. However, due to a quirk in the Health Reform Law, CAHs are subject to review by the Independent Payment Advisory Board (IPAB) starting in 2014, whereas other hospitals aren't subject to IPAB review until 2019. Therefore, they are at a greater risk of funding cuts earlier than other hospitals.

The following criteria must be met in order for a facility to qualify as a CAH:

(1) It must be located in a rural county. It may be either an existing facility or a hospital that closed or downsized to a health center or clinic after November 29, 1989. A facility may be allowed to relocate or rebuild provided it meets the CMS criteria.

(2) The facility must be part of a rural health network with at least one full-service hospital, with agreements regarding patient referral and transfer, communications, and patient transportation;

(3) The facility must be located more than 35 miles from any other hospital or CAH (15 miles for areas with only secondary roads) or must have been certified by the State prior to January 1, 2006 as being a necessary provider of health care services to residents of the area;

(4) The maximum number of licensed beds is 25, which can be operated as any combination of acute or swing-beds;

(5) Required services include: inpatient care, emergency care, laboratory and pharmacy;

(6) Emergency services must be available 24 hours a day, with on-call personnel available within 30 minutes. CMS requires that any hospital, including a CAH, that does not have a physician on site 24 hours per day, 7 days per week, provide a notice to all patients upon admission that addresses how emergency services are provided when a physician is not on site.

(7) The medical staff must consist of at least one physician. Staffing must include nursing on a 24-hour basis; other staffing can be flexible. Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists can provide inpatient care without their supervising physician(s) being on-site.

(8) The annual average length of stay must be less than 96 hours (4 days).

In South Carolina, a hospital located in an urban Metropolitan Statistical Area (MSA) county can still be considered "rural" for the purposes of the CAH program if it meets the following criteria:

(1) It is enrolled as both a Medicaid and Medicare provider and accepts assignment for all Medicaid and Medicare patients;

(2) It provides emergency health care services to indigent patients;

(3) It maintains a 24-hour emergency room;

(4) It staffs 50 or fewer acute care beds; and

(5) It is located in a county with 25% or more rural residents, as defined by the most recent Census.

A total of 1,327 hospitals nationwide had been approved for CAH status as of March 31, 2011. The impact of the Critical Access Hospital Program in South Carolina is a financial one, allowing cost-based reimbursement from Medicare for a facility choosing to participate. The designation as a CAH does not require a change in the licensing of an existing hospital. However, a hospital may be required to de-license a number of beds in order to meet the 25-bed requirement.

The following facilities in South Carolina are designated as CAHs, although there are other hospitals that could potentially be eligible:

Abbeville Memorial Hospital
Allendale County Hospital
Edgefield County Hospital
Fairfield Memorial Hospital
Williamsburg Regional Hospital

The designation of a hospital as a Critical Access Hospital does not require Certificate of Need review, because it does not change the licensing category of the facility. However, an exemption from Certificate of Need review is required for a hospital to reduce the number of licensed beds in

order to meet the criteria for a CAH. Should a hospital later desire to revert to a general acute hospital, a Certificate of Need is required, but the facility may be permitted to increase the number of licensed hospital beds up to the prior number of beds.

D. Obstetrical and Neonatal Services:

1. Obstetrical Services:

Advances in obstetrical and newborn intensive care offer the promise of lower perinatal mortality and improvement in the quality of life for survivors. The high cost of intensive care and the limited availability of skilled personnel have created the requirement for a more efficient method of resource allocation.

Maternal, fetal, and neonatal mortality and morbidity rates can be significantly reduced if patients at high risk are identified early in the pregnancy and optimum techniques for the care of both the mother and infant are applied. High-risk deliveries are a small percent of total annual deliveries, but these patients require a high degree of specialized care. In 2007, 77.7% of all Very Low Birthweight (VLB) babies were born in either a Level III center or a Regional Perinatal Center, whereas the Healthy People 2010 national objective was 90%.

Infant mortality is defined as the death of babies from birth until their first birthday. South Carolina's infant mortality rate for 2009 was 7.1 infant deaths per 1,000 live births versus the national rate of 6.4 infant deaths per 1,000 births.

Neonatal mortality is the death rate for infants up to 28 days old. For 2009, South Carolina's neonatal mortality rate for all races was 4.3 neonatal deaths per 1,000 live births, while the Healthy People 2010 national objective was 2.9 neonatal deaths per 1,000 live births.

Because the cost of high-risk obstetrical and neonatal services is so great, it is not desirable or cost-effective for all hospitals in the state to provide the higher levels of care. Over the years, a regionalized approach to perinatal care has been implemented in South Carolina to address the need for high quality, risk-appropriate, cost-effective perinatal health care. Regionalization provides a coordinated system of perinatal care for a well-defined population group. Each hospital providing perinatal services is designated by DHEC's Division of Health Licensing as a Level I, II, IIE (Enhanced), III Perinatal Hospital, or a RPC (Regional Perinatal Center). Each Level I, II, IIE and III hospital maintains a relationship with its designated RPC for consultation, transport and continuing education. Patients are transferred to the appropriate RPC when medically appropriate, if beds are available. In this way, quality care is provided to mothers and newborn infants, and specially trained perinatal personnel and intensive care facilities can be used efficiently and cost-effectively.

The complete descriptions of the five levels of perinatal services are outlined in Section 607.2 of Regulation Number 61-16: http://www.scdhec.net/administration/regs/docs/61-16.pdf

Community Perinatal Center (Level I): These hospitals provide services for uncomplicated deliveries and normal neonates. The hospital has the capability to manage normal pregnant women and uncomplicated labor and delivery of neonates who are at least 36 weeks of gestation with an anticipated birth weight of greater than 2,000 grams. Hospitals must be able to manage a perinatal patient with acute or potentially life-threatening problems while preparing for immediate transfer to a higher level hospital. CON review is not required for a Level I program.

Specialty Perinatal Center (Level II): In addition to Level I requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. This level of neonatal care includes the management of neonates who are at least 32 weeks of gestation with an anticipated birth weight of at least 1,500 grams. A board-eligible pediatrician must be in the hospital or on site within 30 minutes, 24 hours a day and the hospital must have at least a written consultative agreement with a board eligible neonatologist. These hospitals manage a three year average of at least 500 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals. CON review is not required for a Level II program.

Enhanced Perinatal Center (Level IIE): In addition to Level II requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. Level IIE hospitals may not be located closer than 60 miles from a Regional Perinatal Center. This level of care includes the management of neonates who are at least 30 weeks gestation with an anticipated birth weight of at least 1,250 grams. A board-eligible neonatologist must be in the hospital or on site within 30 minutes, 24 hours a day. These hospitals manage a three year average of at least 1,200 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals. A Certificate of Need is required for a hospital to provide Enhanced Perinatal Center (Level IIE) services.

Subspecialty Perinatal Center (Level III): In addition to Level IIE requirements, these hospitals provide all aspects of perinatal care, including intensive care and a range of continuously available, sub-specialty consultation as recommended in the fourth edition of the *Guidelines for Perinatal Care* (GPC) by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists. A board eligible neonatologist shall be in the hospital or on site within 30 minutes, 24 hours a day. A board certified perinatologist shall be available for supervision and consultation, 24 hours a day. Level III hospitals have the staffing and technical capability to manage high-risk obstetric and complex neonatal patients, including neonates requiring prolonged ventilatory support, surgical intervention, or 24-hour availability of multispeciality management. These hospitals manage a three year average of at least 1,500 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals, or at least an average of 125 neonate admissions that weigh less than 1,500 grams each, require ventilatory support, or require surgery. The establishment of a Level III service requires Certificate of Need review.

Regional Perinatal Center (RPC): In addition to the Level III requirements for management of high-risk obstetric and complex neonatal conditions, the RPC shall provide consultative, outreach, and support services to other hospitals in the region. RPCs manage a three year average of at least 2,000 deliveries annually, or at least an average of 250 neonate admissions that weigh less than 1,500 grams each, require ventilatory support, or require surgery. A board-certified maternal-fetal medicine specialist (perinatologist) must be in the hospital or on site within 30 minutes, 24 hours a day. RPCs participate in residency programs for obstetrics, pediatrics, and/or family practice. No more than one Regional Perinatal Center will be approved in each perinatal region. The establishment of a Regional Perinatal Center requires Certificate of Need review.

2009 OB UTILIZATION AND BIRTHS

FACILITY	BIRTHS	OB BEDS	OB ADM	OB PDS	OCC.%
GREENVILLE MEMORIAL MEDICAL CENTER	4,621	59	4,303	16,924	78.6%
PALMETTO HEALTH BAPTIST	3,522	64	5,511	11,011	47.1%
LEXINGTON MEDICAL CENTER	3,047	33	3,269	6,670	55.4%
SPARTANBURG REGIONAL MEDICAL CTR.	2,860	41	2,998	9,366	62.6%
MUSC MEDICAL CENTER	2,486	36	2,707	8,167	62.2%
SAINT FRANCIS - EASTSIDE	2,434	28	3,466	7,277	71.2%
PALMETTO HEALTH RICHLAND	2,362	42	4,703	11,949	77.9%
PIEDMONT MEDICAL CENTER	2,019	17	2,045	5,238	84.4%
MCLEOD REGIONAL MEDICAL CTR.	2,007	21	2,376	6,623	86.4%
MCLEOD MEDICAL CENTER - DILLON	2,007	21	2,376	6,623	86.4%
TRIDENT MEDICAL CENTER	1,996	25	2,153	4,755	52.1%
ANMED HEALTH WOMEN'S & CHILDREN'S	1,991	28	1,729	4,512	44.1%
BON SECOURS ST. FRANCIS XAVIER	1,868	15	1,946	4,381	80.0%
BEAUFORT MEMORIAL HOSPITAL	1,726	23	1,736	4,411	52.5%
EAST COOPER MEDICAL CENTER	1,684	38	2,054	5,107	36.8%
SELF REGIONAL HEALTHCARE	1,518	37	2,126	5,540	41.0%
REG MED CTR ORANGEBURG-CALHOUN	1,314	32	1,714	4,244	36.3%
TUOMEY	1,255	24	676	4,881	55.7%
SUMMERVILLE MEDICAL CENTER	1,253	12	1,067	2,137	48.8%
CONWAY HOSPITAL	1,252	16	1,526	3,217	55.1%
AIKEN REGIONAL MEDICAL CENTER	1,140	18	1,605	4,125	62.8%
MARY BLACK MEMORIAL HOSPITAL	1,004	21	1,063	2,743	35.8%
GRAND STRAND REGIONAL MED CTR	948	19	1,236	2,579	37.2%
WOMEN'S CENTER / CAROLINAS HOSP. SYS	860	20	811	2,853	39.1%
SPRINGS MEMORIAL HOSPITAL	800	14	147	269	5.3%
CLARENDON MEMORIAL	708	10	728	1,603	43.9%
HILTON HEAD HOSPITAL	657	8	752	1,674	57.3%
PROVIDENCE HOSPITAL NORTHEAST *1*	633	8	603	1,404	48.1%
ROPER HOSPITAL	597	16	836	1,987	34.0%
ALLEN BENNETT/GREER MEMORIAL	590	10	600	1,438	39.3%
CAROLINA PINES REGIONAL MED CTR	581	13	570	2,011	42.4%
OCONEE MEDICAL CENTER	554	15	801	1,843	33.7%
WACCAMAW COMMUNITY HOSPITAL	520	19	1,794	4,956	71.5%
PALMETTO BAPTIST MED CTR EASLEY	496	14	690	1,687	33.0%
LORIS COMMUNITY HOSPITAL	428	8	625	1,287	44.1%
KERSHAW HEALTH	411	10	551	1,197	32.8%
GEORGETOWN MEMORIAL HOSPITAL	394	14	828	2,022	39.6%
COLLETON MEDICAL CENTER	389	6	482	3,203	146.3%
UPSTATE CAROLINA MEDICAL CENTER	380	15	528	1,155	21.1%
LAURENS COUNTY HOSPITAL	371				
NEWBERRY COUNTY MEMORIAL HOSPITAL	360	3	403	798	72.9%
CHESTERFIELD GENERAL HOSPITAL	168	9	241	612	18.6%
MARLBORO PARK HOSPITAL	112	8	212	460	15.8%
WALLACE THOMSON HOSPITAL	75	7	96	243	9.5%
BAMBERG COUNTY MEMORIAL HOSPITAL	15	2	14	30	4.1%
MARION REGIONAL HOSPITAL 2	DNR				
TOTAL BIRTHS	56,398				

1 DISCONTINUED PERINATAL SERVICES 1/1/12

2 BIRTHS FOR 2010 NOT REPORTED

The need for obstetrical beds will be evaluated based on information supplied by the Joint Annual Report of Hospitals and other sources. Those facilities experiencing low utilization and in close proximity to one another should consider consolidating services, where appropriate.

Quality

Cesarean sections are identified as a potentially over-used procedure, although an optimal rate has not been determined. While the appropriateness of a c-section depends on the patient's characteristics, it is largely impacted by the individual physician's practice patterns. Hospital rankings need to be risk-adjusted, but, overall, a lower c-section rate is viewed as representing higher quality. Conversely, a higher rate of Vaginal Birth After Cesarean (VBAC) equates to higher quality. To the extent practical, hospitals should attempt to lower their c-section rates.

Source: http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

Relative Importance of Project Review Criteria

The following project review criteria are considered the most important in evaluating Certificate of Need applications for an obstetrical service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Acceptability;
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

The following hospitals have requested a Perinatal Capability Review and have been designated as a Level II, Level IIE, Level III or RPC facility:

Regional Perinatal Centers

Greenville Memorial Medical Center
McLeod Regional Medical Center of the Pee Dee
MUSC Medical Center
Palmetto Health Richland
Spartanburg Regional Medical Center

Subspecialty Perinatal Center (Level III Hospital)

Palmetto Health Baptist
Self Regional Healthcare

Enhanced Perinatal Center (Level II Enhanced Care Hospitals)

Piedmont Medical Center

Specialty Perinatal Centers (Level II Hospitals)

Aiken Regional Medical Center
AnMed Health Women's and Children's Hospital
Baptist Easley Hospital
Beaufort Memorial Hospital
Bon Secours-St. Francis Xavier Hospital
Carolina Pines Regional Medical Center
Conway Hospital
East Cooper Medical Center
Georgetown Memorial Hospital
Grand Strand Regional Medical Center
Lexington Medical Center
Marion County Medical Center
Mary Black Memorial Hospital
Regional Medical Center of Orangeburg/Calhoun Counties
Roper Hospital
St. Francis - Eastside
Springs Memorial Hospital
Summerville Medical Center
Trident Medical Center
Tuomey
Waccamaw Community Hospital
The Women's Center of Carolinas Hospital System

2. Neonatal Services:

Neonatal services are highly specialized and are only required by a very small percentage of infants. The need for these services is affected by the incidence of high-risk deliveries, the percentage of live births requiring neonatal services, and the average length of stay. The limited need for these services requires that they be planned for on a regional basis, fostering the location of these specialized units in hospitals that have the necessary staff, equipment, and consultative services and facilities. Referral networks facilitate the transfer of infants requiring this level of services from other facilities.

The inventory of Intensive and Intermediate Bassinets by Perinatal Region is as follows:

Perinatal Region	Existing Bassinets Intensive	Intermediate
Anderson, Abbeville, Edgefield, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Saluda		
Palmetto Baptist Medical Center - Easley	0	4
Greenville Memorial Medical Center	12	68
AnMed Health Women's & Children's Hospital	0	13
St. Francis Women's & Family Hospital	0	10
Self Regional Healthcare	7	11
SUBTOTAL	19	106
Cherokee, Chester, Spartanburg, Union		
Spartanburg Regional Medical Center	13	22
Mary Black Memorial Hospital	0	10
SUBTOTAL	13	32
Aiken, Allendale, Bamberg, Barnwell, Calhoun, Clarendon, Fairfield, Kershaw, Lancaster, Lee, Lexington, Newberry, Orangeburg, Richland, Sumter, York		
Palmetto Health Richland	31	38
Palmetto Health Baptist	8	22
Lexington Medical Center	0	20
Piedmont Medical Center	0	12
Springs Memorial Hospital	0	4
Aiken Regional Medical Center	0	8
Regional Med Center Orangeburg-Calhoun	0	10
Tuomey	0	22
SUBTOTAL	39	136
Chesterfield, Darlington, Dillon, Florence, Horry, Marion, Marlboro, Williamsburg		
Carolina Pines Regional Medical Center	0	4
Marion County Medical Center	0	2
McLeod Regional Medical Ctr. of Pee Dee	12	28
Conway Hospital	0	6
Grand Strand Regional Medical Center	0	2
Women's Center of Carolinas Hospital System	0	11
SUBTOTAL	12	53
Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Georgetown		
Beaufort Memorial Hospital	0	5
Georgetown Memorial Hospital	0	5
Waccamaw Community Hospital	0	2
MUSC Medical Center	32	34
East Cooper Medical Center	0	10
Bon Secours-St. Francis Xavier Hospital	0	11
Summerville Medical Center	0	3
Trident Medical Center	0	10
Roper Hospital	0	5
SUBTOTAL	32	101
STATEWIDE TOTAL	115	412

The 2010 utilization of neonatal special care units by facility follows. Note that some facilities did not report using any of their intermediate care bassinets.

HOSPITAL	ICU Bassinets	ICU Pt Days	Intermed Bassinets	Intermed Pt Days	Total Bassinets	Total Pt Days	Total Occupancy
AnMed Health Women's			13	1,349	13	1,349	28.4%
Greenville Memorial	12	5,333	68	12,797	80	18,130	62.1%
St. Francis-Eastside			10	1,490	10	1,490	40.8%
Palmetto Baptist-Easley			4	0	4	0	0.0%
Self Regional	7	345	11	1,767	18	2,112	32.1%
REGION SUBTOTAL	19	5,678	106	17,403	125	23,081	50.6%
Mary Black Memorial			10	550	10	550	15.1%
Spartanburg Regional	13	6,959	22	3,000	35	9,959	78.0%
REGION SUBTOTAL	13	6,959	32	3,550	45	10,509	64.0%
Aiken Regional Med Ctr			8	379	8	379	13.0%
Springs Memorial Hosp			4	815	4	815	55.8%
Lexington Medical Ctr			20	2,855	20	2,855	39.1%
Reg Med Ctr Orangeburg			10	0	10	0	0.0%
Palmetto Health Baptist	8	1,552	22	4,196	30	5,748	52.5%
Palmetto Health Richland	31	8,976	38	12,225	65	21,201	89.4%
Tuomey			22	535	22	535	6.7%
Piedmont Medical Ctr			12	1,406	12	1,406	32.10%
REGION SUBTOTAL	39	10,528	136	22,411	175	32,939	52.77%
Carolina Pines Regional			4	60	4	0	0.4%
McLeod Regional	12	4,612	28	4,948	40	9,560	65.5%
Women's Ctr Carolinas			11	811	11	811	20.2%
Conway Hospital			6	446	6	446	20.4%
Grand Strand Regional			2	979	2	979	134.1%
Marion Co Medical Ctr			2	0	2	0	0.0%
REGION SUBTOTAL	12	4,612	53	7,244	65	11,796	49.7%
Beaufort Memorial Hosp			5	98	5	98	5.4%
Bon Secours-St. Francis			11	1,053	11	1,053	26.2%
East Cooper Medical Ctr			10	686	10	686	18.8%
MUSC Medical Center	16	6,837	50	12,178	66	19,015	78.9%
Roper Hospital			5	173	5	173	9.5%
Trident Medical Center			10	2,772	10	2,772	75.9%
Summerville Med. Ctr.			3	0	3	0	0.0%
Georgetown Memorial			5	105	5	105	5.8%
Waccamaw Community			2	291	2	291	39.9%
REGION SUBTOTAL	16	6,837	101	17,356	117	24,193	56.7%
GRAND TOTAL	99	34,614	428	67,964	527	102,518	53.8%

STANDARDS

1. The projected need for neonatal intensive care bassinets is calculated on a regional basis:

   A. For each region take the average number of births from 2008-2010 and the average population of women age 15-44 for 2008-2010 to generate an average birth rate.

   B. Multiply the average birth rate against the projected 2012 population of women age 15-44 to project the number of births in 2012.

   C. Calculate the average number of patient days per region by combining and then dividing the patient days for 2009 and 2010.

   D. Divide the projected 2012 births by the actual 2010 births to compute a growth rate in the number of births.

   E. The average number of patient days for 2009-2010 is multiplied against the growth rate to project the number of patient days for 2012.

   F. The projected number of patient days for 2012 is divided by a 65% occupancy factor to generate the projected number of NICU bassinets in a region.

2. Only Level III and RPCs neonatal units have intensive care bassinets.

The addition of neonatal intermediate care bassinets does not require Certificate of Need review. The need for intermediate neonatal bassinets is calculated based on the utilization of the individual providers using a 65% occupancy factor. Note that some Level II hospitals did not report any utilization for the intermediate care bassinets and the occupancy rate is reflected as zero, which decreases the need calculations.

Note: S.C. presently has 2.0 neonatal intensive care bassinets and 7.1 neonatal intermediate care bassinets per 1,000 births.

In some areas the number of intensive care bassinets should be increased. The intermediate care bassinets should be better utilized in Level II and Level IIE facilities so babies can be transferred back closer to their home community potentially alleviating the high utilization of the current intensive/intermediate care bassinets in RPC facilities in some areas of the State. To improve the availability of the existing RPC neonatal intensive care bassinets, utilization of the back transport concept should be supported. This component of regionalized care involves the transfer of infants who no longer require neonatal intensive care to facilities with intermediate or continuing care bassinets appropriate to the individual baby's care needs. If more back transfers to the Level II and/or Level IIE facilities occurred, then some of the overcrowding problems of the existing RPC units would be alleviated.

It should be noted that some RPC and Level III facilities with intensive care bassinets may at

NEONATAL INTENSIVE CARE BASSINETS NEED METHODOLGY

REGIONS	2008-2010 AVE # OF BIRTHS	2008-2010 AVE FEM 15-44 POP	AVE BIRTH RATE	2012 FEM 15-44 POP	2012 PROJ BIRTHS	2009-2010 AVE PT DAYS	2012 PROJ BIRTHS / 2010 BIRTHS	2012 PROJ PT DAYS	65% OCCUP	PROJ NEED	EXISTING	BED NEED
Abbeville	270	4,723		4,600								
Anderson	2,333	35,307		36,000								
Edgefield	225	4,381		4,400								
Greenville	6,409	91,914		94,500								
Greenwood	958	14,545		15,000								
Laurens	856	13,333		12,800								
McCormick	82	1,204		1,100								
Oconee	825	12,312		12,700								
Pickens	1,241	25,211		26,700								
Saluda	256	3,464		3,500								
TOTAL	13,456	206,395	0.0652	211,300	13,775	5,867	1.0238	6,006	237	25	19	6
Cherokee	705	11,051		11,300								
Chester	424	6,253		6,300								
Spartanburg	3,875	57,069		57,800								
Union	340	5,134		5,200								
TOTAL	5,345	79,507	0.0672	80,600	5,418	6,756	1.0137	6,849	237	29	13	16
Aiken	1,978	29,909		30,800								
Allendale	128	1,719		1,800								
Bamberg	183	3,089		3,000								
Barnwell	302	4,293		4,200								
Calhoun	168	2,650		2,500								
Clarendon	385	5,658		5,800								
Fairfield	250	4,380		4,300								
Kershaw	793	11,105		11,400								
Lancaster	921	14,535		14,100								
Lee	218	3,388		3,200								
Lexington	3,456	51,488		54,000								
Newberry	503	7,018		6,800								
Orangeburg	1,320	18,740		18,700								
Richland	5,019	88,700		91,000								
Sumter	1,608	21,605		21,800								
York	3,006	47,288		48,900								
TOTAL	20,240	315,565	0.0641	322,300	20,672	10,614	1.0213	10,841	237	46	39	7
Chesterfield	555	8,476		8,800								
Darlington	825	13,068		13,100								
Dillon	472	6,122		6,200								
Florence	1,874	27,637		28,400								
Horry	3,167	48,841		50,900								
Marion	463	6,511		6,300								
Marlboro	338	4,938		4,800								
Williamsburg	412	6,164		6,000								
TOTAL	8,105	121,757	0.0666	124,500	8,287	4,466	1.0225	4,566	237	19	12	7
Beaufort	2,240	27,315		27,500								
Berkeley	2,597	37,106		37,600								
Charleston	5,022	77,910		76,100								
Colleton	511	7,188		7,000								
Dorchester	1,860	27,775		29,000								
Georgetown	671	10,146		9,600								
Hampton	280	3,767		3,800								
Jasper	366	4,234		4,600								
TOTAL	13,547	195,441	0.06932	195,200	13,530	7,221	0.9988	7,212	237	30	32	-2
STATEWIDE	60,692	918,666	0.06607		61,683	34,923				150	115	35

INTERMEDIATE BASSINET NEED

Hospital	Intermed Bassinets	2010 Pt Days	Intermed ADC	Occupancy Factor	Projected Need	To Be Added
AnMed Health Women's	13	1,349	4	0.65	6	-7
Greenville Memorial	68	12,797	35	0.65	54	-14
St. Francis-Eastside	10	1,490	4	0.65	6	-4
Palmetto Baptist-Easley	4	0	0	0.65	0	-4
Spartanburg Regional	22	3,000	8	0.65	13	-9
Mary Black Memorial	10	550	2	0.65	2	-8
Self Regional	11	1,767	5	0.65	7	-4
Aiken Regional Med Ctr	8	379	1	0.65	2	-6
Springs Memorial Hosp	4	815	2	0.65	3	-1
Lexington Medical Ctr	20	2,855	8	0.65	12	-8
Reg Med Ctr Orangeburg	10	0	0	0.65	0	-10
Palmetto Health Baptist	22	4,196	11	0.65	18	-4
Palmetto Health Richland	38	12,225	33	0.65	51	13
Tuomey	22	535	1	0.65	2	-20
Piedmont Medical Ctr	12	1,406	4	0.65	6	-6
Carolina Pines Regional	4	60	0	0.65	0	-4
McLeod Regional Med Ctr	28	4,948	14	0.65	21	-7
Women's Ctr Carolinas	11	811	2	0.65	3	-8
Conway Hospital	6	446	1	0.65	2	-4
Grand Strand Regional	2	979	3	0.65	4	2
Marion Co Medical Ctr	2	0	0	0.65	0	-2
Beaufort Memorial Hosp	5	98	0	0.65	0	-5
Bon Secours-St. Francis	11	1,053	3	0.65	4	-7
East Cooper Med Ctr	10	686	2	0.65	3	-7
MUSC Medical Center	34	12,178	33	0.65	51	17
Roper Hospital	5	173	0	0.65	1	-4
Trident Medical Center	10	2,772	8	0.65	12	2
Summerville Med. Ctr.	3	0	0	0.65	0	-3
Georgetown Memorial	5	105	0	0.65	0	-5
Waccamaw Community	2	291	1	0.65	1	-1
Totals	412	67,964	186		286	-126

times have intermediate type infants in intensive care bassinets and vice versa as the patient load changes within the unit. RPCs may use intermediate and intensive care bassinets interchangeably as the level of care required by the neonate varies.

Relative Importance of Project Review Criteria

The following criteria are considered the most important in evaluating certificate of need applications for a neonatal service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Acceptability
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

Because neonatal services are planned and located regionally due to the very small percentage of infants requiring neonatal services, this service is available within approximately 90 minutes for the majority of the population. Of more importance is the early identification of mothers who potentially will give birth to a baby needing this specialized service and directing them to the appropriate neonatal center. There is a need for additional intensive care bassinets in some areas. A few additional Level II (intermediate) bassinets are needed; however, the existing intermediate care bassinets are not used in some hospitals. The benefits of improved accessibility will be equally weighed with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

E. Pediatric Inpatient Services:

A pediatric inpatient unit is a specific section, ward, wing or unit devoted primarily to the care of medical and surgical patients less than 18 years old, not including special care for infants. It is recognized that children have special problems that need to be addressed by specialized facilities, equipment and personnel experienced in dealing with children, and understanding and sympathetic to the child's unique needs. It is also recognized that each hospital need not develop the capability to provide all types of pediatric care. Pediatric beds are licensed as general hospital beds and no separate need is calculated for them.

Quality

The Agency for Health Research and Quality (AHRQ) lists 13 provider-level quality indicators for pediatric services. Not all indicators are applicable for all hospitals. These include: accidental puncture and laceration; decubitus ulcer; foreign body left in during a procedure; iatrogenic pneumothorax in neonates and non-neonates; in-hospital mortality for pediatric heart surgery; volume of pediatric heart surgery; post-operative hemorrhage or hematoma; post-operative respiratory failure; post-operative sepsis; post-operative wound dehiscence (opening of a wound along the suture line); infection due to medical care; and transfusion reaction. South Carolina hospitals should be lower than or comparable to the national averages for these indicators.

Link: http://www.qualityindicators.ahrq.gov/downloads/pdi/2006-Feb-PediatricQualityIndicators.pdf

Relative Importance of Project Review Criteria

The following criteria are considered the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Acceptability;
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

In many hospitals, pediatric beds/services are not physically separated from other general hospital beds. Only larger hospitals have distinct pediatric units. General hospital beds are located within approximately 30 minutes travel time for the majority of the residents of the State. There may be a need for additional pediatric beds in the existing general hospitals; however, additional beds for pediatric services will not be approved unless other beds are converted to pediatrics or a need is indicated in the Plan for additional hospital beds. The benefits of improved accessibility do not outweigh the adverse affects caused by the duplication of this existing service.

F. Pediatric Long Term Acute Care Hospitals:

Pediatric Long Term Care Hospitals (PLATCHs) are specialized health care facilities designed to provide care for children up to age 21 who have complex medical conditions that require extensive care on a long-term basis (similar to adult LTACHs). Care may be rehabilitative or palliative. These facilities are designed to be as non-institutional as possible while meeting the psychological, physical, and emotional needs of chronically ill children and their families. To be admitted, children must have ongoing health conditions that require both medical and nursing supervision and specialized equipment or services.

Patients often have three or more chronic conditions. These may include Neonatal Abstinence Syndrome (NAS), birth defects, spinal cord or trauma injury, seizure disorders, chronic lung disease, and extensive wound care. Many are non-ambulatory and dependent on medical technology such as ventilators, feeding tubes, IV infusions, and mobility devices.

The DHEC Division of Children with Special Health Care Needs has a caseload of approximately 12,000 children and it is envisioned that many of these clients would be candidates for Pediatric LTACH services. These patients are currently either staying for extended periods in one of the state's Children's Hospitals (Greenville Hospital System, Palmetto Health, McLeod, and MUSC) or are receiving daily therapy in their own homes. Neither option is optimal for these patients.

Pediatric LTACH facilities are currently located primarily in the Northeast and California. They are potentially a less costly alternative to maintaining these children in an acute care facility. Some states have nursing homes that specialize in extended care for pediatric patients, but there are currently no such facilities in South Carolina.

Certificate of Need Standards

1. An application for a Pediatric Long Term Acute Care Hospital must be in compliance with the relevant standards in DHEC Regulation No. 61-16, Licensing Standards for Hospitals and Institutional General Infirmaries.

2. Although Pediatric Long Term Acute Care Hospital beds are not considered to be a separate category for licensing purposes, they will be inventoried separately from general acute care hospital beds for planning purposes.

3. The utilization of PLTACHs is not included in the bed need for general acute care hospital beds. No bed need will be calculated for Pediatric Long Term Acute Care Hospital beds. An applicant must document the need for PLTACH beds.

4. An applicant for PLTACH beds must submit an affiliation agreement with a SC Children's Hospital. This affiliation agreement will at a minimum include a transfer agreement and coverage for specialized medical services.

5. Should a hospital lease general beds to another entity to create a Pediatric Long Term Acute Care Hospital, that hospital shall be entitled to regain these beds once the lease is terminated. No entity other than the hospital that initially leased the general acute beds (or its successor) to the Pediatric Long Term Acute Care Hospital shall be entitled to obtain the rights to the beds upon termination of the lease. A Certificate of Need application is required.

6. A hospital that desires to be designated as a Pediatric LTACH must restrict admissions to patients under the age of 21 who require long-term medical care. Once licensed, a Pediatric LTACH must remain licensed as such. Should the facility attempt to provide care that is inconsistent with this requirement or patient demand or other economic conditions require the facility to close, the CON issued to that hospital for that purpose shall be revoked. The entity that has had its CON revoked shall not have the authority to operate as a general acute care hospital and the licensed beds operated by the facility will be removed from the bed inventory.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Financial Feasibility.

There are currently no Pediatric Long Term Acute Care Hospital beds in South Carolina. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

CHAPTER IV

PSYCHIATRIC SERVICES

A. Community Psychiatric Beds:

Inpatient psychiatric services are those services provided to patients who are admitted to institutions for the evaluation, diagnosis, and treatment of mental, emotional, or behavioral disorders. Services may be provided in either psychiatric units of general hospitals or freestanding psychiatric hospitals.

Special units for children and adolescents and geriatric patients have been developed throughout the state. If any additional beds are approved, they must come from the overall psychiatric bed component shown as needed. These specialty psychiatric services should be identifiable units with sufficient space to have available areas for sleeping, dining, education, recreation, occupational therapy and offices of evaluation and therapy. The unit should be staffed with an appropriate multi-disciplinary care team of psychiatrists, psychologists, social workers, nurses, occupation therapists, recreational therapists, and psychiatric technicians. Other consultants should be available as needed.

A major issue that general hospitals face is having their emergency departments over-burdened with patients requiring psychiatric care. Under EMTALA hospitals have to provide care for these patients whether or not they have insurance. Medicaid does not pay for psychiatric care provided by freestanding psychiatric hospitals, known as Institutions for Mental Disease (IMDs), because at the time the program was created mental health funding was considered to be the responsibility of the state. However, this may eventually change. On March 13, 2012, CMS announced a three-year project called the Medicaid Emergency Psychiatric Demonstration that could lead to Medicaid reimbursement for these hospitals. Eleven participating states, including North Carolina, will create Medicaid programs for psychiatric patients age 21-64 seeking emergency treatment at IMDs. The theory is that the IMDs can provide care for cheaper than warehousing them in hospital EDs. If the pilot project is successful, Congress may revise the Medicaid funding for psychiatric care nationally.

The existing psychiatric programs in the state are:

Region	Facility	County	Beds	2010 Occupancy
I	AnMed Health Medical Ctr.	Anderson	38	45.0%
I	Carolina Ctr. Behavioral Health	Greenville	104	79.6% *1*
I	Greenville Memorial Med. Ctr.	Greenville	46	83.9%
I	Springbrook Behavioral Health	Greenville	37	68.8% *2*
I	Mary Black Memorial	Spartanburg	15	68.3%
I	Spartanburg Regional Med. Ctr.	Spartanburg	56	25.1%
II	Self Memorial Regional	Greenwood	36	38.4%
II	Three Rivers Behavioral Health	Lexington	81	82.0%
II	Palmetto Health Baptist	Richland	94	65.1%

II	Palmetto Health Richland	Richland	60	25.4%	
II	Piedmont Medical Center	York	20	63.4%	
III	McLeod – Darlington	Darlington	23	58.5%	
III	Carolinas Hospital System	Florence	12	46.0%	
III	Lighthouse of Conway	Horry	59	79.9%	*3*
III	Marlboro Park Hospital	Marlboro	8	35.3%	
IV	Aiken Regional Med. Ctr.	Aiken	41	85.2%	*4*
IV	Beacon Harbor	Beaufort	22	---	*5*
IV	Beaufort Memorial	Beaufort	14	52.7%	
IV	Medical University SC	Charleston	82	57.1%	
IV	Palmetto Lowcountry Behavioral	Charleston	70	56.5%	
IV	Colleton Medical Center	Colleton	4	---	*6*
IV	RMC – Orangeburg & Calhoun	Orangeburg	15	52.1%	
SW	William J. McCord Adolescent	Orangeburg	(15)	98.1%	*7*
		Total	937	60.7%	

1 CON issued 8/10/09 to add 23 beds for a total of 99; 8 additional beds licensed for a total of 84 2/16/10. Licensed for 99 beds 9/23/10. CON issued 4/26/12 to add 5 beds for a total of 104.

2 CON issued 8/10/09 to add 17 beds for a total of 37. Licensed 8 additional beds for a total of 28 9/20/11.

3 CON issued 1/25/10 to add 15 beds for a total of 59.

4 CON issued 8/12/10 for the addition of 12 psych beds for a total of 41. Licensed for 41 psych beds 2/2/12.

5 CON issued 8/13/10 to construct a 22 bed psychiatric hospital.

6 CON issued 5/13/11 for the addition of 4 psychiatric beds; beds licensed 9/30/11.

7 CON issued 7/16/10 to re-classify William J. McCord Adolescent Treatment Facility as a specialized hospital with 15 psychiatric beds restricted for the primary purpose of providing alcohol and drug services to adolescents (see Section B.3.).

Certificate of Need Standards

1. Need projections are based on psychiatric service areas.

2. The bed need methodology takes the greater of the actual utilization of the facilities in the service area or 75% of the statewide average beds per 1,000 population to project need. Should the service area show a need for additional beds, then the maximum of the actual projected bed need or up to 20 additional beds may be approved for the construction of an economical unt.

3. For service areas without existing psychiatric units and related utilization data, the statewide average beds per 1,000 population was used in the projections.

PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	2010 POP	2017 POP	EXISTING BEDS	2010 PDS	PROJ ADC	% OCC	BED NEED (USE)	+/-	BED NEED (SW)	+/-	BED NEED
ANDERSON,OCONEE	<65	218,964	227,800		4,733	13.49						
	+65	42,435	52,000		1,510	5.07						
	TOTAL	261,399	279,800	38	6,243	18.56	0.70	27	-11	42	4	4
GREENVILLE,PICKENS	<65	496,875	527,200		36,628	106.48						
	+65	73,574	89,900		7,815	26.16						
	TOTAL	570,449	617,100	187	44,443	132.64	0.70	189	2	94	-93	2
CHEROKEE,SPARTANBURG	<65	318,172	330,300		3,417	9.72						
UNION	+65	50,438	61,300		5,460	18.18						
	TOTAL	368,610	391,600	71	8,877	27.90	0.70	40	-31	59	-12	-12
CHESTER,LANCASTER	<65	304,043	312,000		4,305	12.10						
YORK	+65	42,198	53,600		323	1.12						
	TOTAL	346,241	365,600	20	4,628	13.23	0.70	19	-1	55	35	35
ABBEVILLE,EDGEFIELD	<65	184,805	191,000		4,437	12.56						
GREENWOOD,LAURENS	+65	33,903	42,100		609	2.07						
MCCORMICK,SALUDA	TOTAL	218,708	233,100	36	5,046	14.64	0.70	21	-15	35	-1	-1
FAIRFIELD,KERSHAW	<65	682,083	713,500		42,536	121.90						
LEXINGTON,NEWBERRY	+65	87,973	114,400		9,586	34.15						
RICHLAND	TOTAL	770,056	827,900	235	52,122	156.06	0.70	223	-12	126	-109	-12
DARLINGTON,FLORENCE	<65	205,966	206,000		5,126	14.05						
MARION	+65	32,662	41,900		1,858	6.53						
	TOTAL	238,628	247,900	35	6,984	20.58	0.70	29	-6	38	3	3
CHESTERFIELD,DILLON	<65	93,459	91,500		640	1.72						
MARLBORO	+65	14,270	17,400		392	1.31						
	TOTAL	107,729	108,900	8	1,032	3.03	0.70	4	-4	17	9	9
CLARENDON,LEE,SUMTER	<65	139,263	140,600		0	0.00						
	+65	22,384	28,700		0	0.00						
	TOTAL	161,647	169,300	0	0	0.00	0.70	0	0	26	26	26
GEORGETOWN,HORRY	<65	300,843	317,900		7,799	22.58						
WILLIAMSBURG	+65	63,029	85,800		5,038	18.79						
	TOTAL	363,872	403,700	59	12,837	41.37	0.70	59	0	61	2	2
BAMBERG,CALHOUN	<65	104,894	104,100		1,922	5.23						
ORANGEBURG	+65	18,769	23,800		931	3.23						
	TOTAL	123,663	127,900	15	2,853	8.46	0.70	12	-3	19	4	4
ALLENDALE,BEAUFORT	<65	178,514	185,300		2,548	7.25						
HAMPTON,JASPER	+65	40,005	57,000		145	0.57						
	TOTAL	218,519	242,300	36	2,693	7.81	0.70	11	-25	37	1	1
BERKELEY,CHARLESTON	<65	621,057	633,900		29,796	83.32						
COLLETON,DORCHESTER	+65	82,442	111,600		1,735	6.43						
	TOTAL	703,499	745,500	156	31,531	89.76	0.70	128	-28	113	-43	-28
AIKEN,BARNWELL	<65	154,928	162,800		8,119	23.37						
	+65	27,792	35,400		902	3.15						
	TOTAL	182,720	198,200	41	9,021	26.81	0.70	38	-3	30	-11	-3
	TOTAL			937				800	-137	752	-185	31
STATE TOTAL	<65	4,003,866	4,143,900	0.000152	152,937	0.039573793	0.03					
	+65	631,874	814,900		37,295	0.061190504	0.05					
	TOTAL	4,635,740	4,958,800		190,232	0.0425	0.03					

4. Priority should be given to excess general hospital beds that can be economically and cost effectively converted for use as a specialized psychiatric unit over the construction of new beds, if such beds will be accessible to the target population.

Quality

The Hospital-Based Inpatient Psychiatric Services (HBIPS) project grew from a partnership among the National Association of Psychiatric Health Systems, the National Association of State Mental Health Program Directors, the American Psychiatric Association and the Joint Commission. The HBIPS core measures focus on critical issues that affect the course of a patient's hospitalization, such as admissions screening and having a coordinated plan for continuity of treatment. Other measures address the use of anti-psychotic medications and the reduction in the use of restraints and seclusion. Collection and reporting of these measures are expected to become mandatory starting in 2013, and pilot testing of pay-for-performance measures by 2016. All South Carolina hospitals that offer inpatient psychiatric services should support the HBIPS project and be in compliance with its core measures.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Ability of the Applicant to Complete the Project;
g. Cost Containment; and
h. Staff Resources.

Psychiatric beds are planned for and located within sixty (60) minutes travel time for the majority of the residents of the State. In addition, current utilization and population growth are factored into the methodology for determining psychiatric bed need. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these services.

B. State Mental Health Facilities:

1. Psychiatric Hospital Beds:

The S.C. Department of Mental Health (DMH) operates a variety of psychiatric facilities. The Department has analyzed the patient population and plans to provide psychiatric services in the least restrictive environment, maintain patients in the community, and keep hospitalization to a minimum.

Since DMH cannot refuse any patient assigned to them by a court, renovation, replacement, and expansion of the component programs should be allowed as long as the overall psychiatric hospital complement is maintained or reduced. As long as the Department of Mental Health does not add any additional beds over the 3,720 beds that were in existence on July 1, 1988, any changes in facility bed capacity are exempt from Certificate of Need review.

2. Local Inpatient Crisis Stabilization Beds:

Because the South Carolina Department of Mental Health (SCDMH) has had substantial decreases over the past several years in inpatient capacity, insufficient adult inpatient beds are available to meet the demand from referral sources for its beds. In a number of regions of the State, this has led to significant numbers of persons in a behavioral crisis waiting in hospital emergency rooms inordinate periods of time for an appropriate inpatient psychiatric bed to become available. These emergency room patients may not have a source of funding.

SCDMH has attempted to alleviate this problem by means of its "Crisis Stabilization Program." Within available funding limits, the "Crisis Stabilization Program" is to provide short-term emergency stabilization of psychiatric patients in the local community, by use of both local hospital beds and non-hospital residential programs, such as community residential care facilities, for those patients who do not require a hospital level of care. For patients needing stabilization in a hospital, subject to available funding, the SCDMH contracts with one or more local hospitals willing to admit indigent patients assessed by the SCDMH mental health center as needing acute care in return for a daily rate for a defined period. These patients can be cared for in licensed general acute care beds or licensed psychiatric beds.

Due to the low utilization, the Plan only projects a need for a small number of additional psychiatric beds in some service areas. To assist in alleviating the problems described above, the following policies will apply.

1. Should a hospital propose to contract with the SCDMH to provide Crisis Stabilization services in existing acute care or existing psychiatric beds, then a Certificate of Need is not required.

2. Should a hospital propose to contract with the SCDMH to provide Crisis Stabilization services and desire to add psychiatric beds, a Certificate of Need is required. These additional beds could be approved if the Plan indicates a need for additional beds or some small number (ten beds or less) of additional beds could be approved for crisis stabilization patients only. These beds would not be restricted to any specific age group except that the patients would have to be over age 18.

3. An application for a Certificate of Need for Crisis Stabilization patients only must be accompanied by information from the SCDMH to verify this additional need, such as the number of patients currently awaiting treatment, the estimated average length of stay, the pay source for the patients, the number of patients emergently admitted to SCDMH hospitals over the past year from the area, the number of crisis patients that are expected to require this

service annually, and other information to justify these additional psychiatric beds. In addition, the SCDMH will supply verification that it made contact with all hospitals in the county and contiguous counties to notify them of the potential for adding some psychiatric beds to the area. The hospital seeking the Certificate of Need will provide the necessary care for these individuals referred by the SCDMH and may be reimbursed by for the care of the patients if there are sufficient funds, but the hospital must identify the minimum number of indigent (no source of funding) patient days it will provide to patients referred by SCDMH. Should the contract with SCDMH terminate for any reason or should the hospital fail to provide care to the patients referred from the SCDMH, the license for these beds will be voided.

Based upon on-going patient analysis by DMH, consideration should be given to converting psychiatric hospital beds to other levels of care in order to accommodate the level of functioning of the patients if alternative community-based resources are not available. DMH will justify any changes in bed or service categories. Patients appropriate for de-institutionalization should be discharged when the appropriate community support services are in place.

3. William J. McCord Adolescent Treatment Facility:

The William J. McCord Adolescent Facility is a facility that has provided substance abuse treatment for adolescents statewide for a number of years. It was previously licensed as a specialized hospital with 15 substance abuse beds. Because of changes in reimbursement, McCord received a CON on 7/16/10 to convert to a specialized hospital with 15 psychiatric beds restricted primarily for the provision of alcohol and drug abuse treatments for adolescents. Although now licensed as a psychiatric hospital, the facility has not changed its scope of services. The bed classification change was made in order to continue receiving reimbursement. These beds are not counted in the psychiatric bed need calculations.

C. Critical Access Hospital Pilot Project:

On May 23, 2011 the General Assembly approved a pilot project to assess the provision of psychiatric crisis stabilization services for patients age 65 and over in Critical Access Hospitals (CAHs). The project will be conducted at two different CAHs and be coordinated between DHEC and the South Carolina Department of Mental Health (DMH). To the extent practicable, the CAHs must be located in different regions of the state and have different racial and socioeconomic demographics. Selection criteria include population trends, access to services for elderly patients in rural communities, the resources required to provide these services, the impact of increased accessibility, and the economics of the health care delivery system.

The participating facilities may license 10 beds to establish a Distinct Part Psychiatric unit for Prospective Payment System Exclusion, as defined by the Federal Centers for Medicare and Medicaid Services (CMS) for the purpose of conducting this project. If a participating hospital de-licensed beds prior to the commencement of the project in order to qualify as a CAH, the facility may re-license up to 10 of the original bed complement in order to participate.

The CAH must request a written exemption from the Department but a CON is not required for participation in the project. The Distinct Part Psychiatric unit must meet all applicable state and federal laws and regulations, including all licensing and certification requirements, and all the requirements pertaining to the Emergency Medical Treatment and Active Labor Act (EMTALA).

A CAH wishing to participate in the project must apply for selection to the Department by July 1, 2012. The 10 beds designated to participate must be licensed by July 1, 2013. The project must conclude no later than July 1, 2016. If the beds established by this pilot project are de-certified or the pilot project is closed, the CAH must not operate the beds for any other use. The pilot project beds must not be interchanged or combined with beds of other units and must be physically located on the same site as the hospital.

Upon completion of the project, DHEC and DMH will submit a report to the SHPC in order to advise the DHEC Board whether new standards and criteria should be established in the Plan regarding the accessibility of psychiatric services for patients age 65 and over in a psychiatric crisis situation. Williamsburg Regional Hospital received an Exemption on 8/25/11 to participate in the pilot project.

CHAPTER V

REHABILITATION FACILITIES

A rehabilitation facility is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program under competent professional supervision. A comprehensive physical rehabilitation service provides an intensive, coordinated team approach to care for patients with severe physical ailments and should be located where an extensive variety of professionals representing medical, psychological, social, and vocational rehabilitation evaluation and services are available. These beds are viewed as being comprehensive in nature and not limited only to a particular service or specialty. Patients with impairments such as spinal cord injury, traumatic brain injury, neuromuscular diseases, hip fractures, strokes, and amputations are typical clients. CMS identified 13 specific conditions for which facilities must treat 75% of their patients in order to qualify for Medicare reimbursement; however, legislation was signed that froze this threshold at 60% and allowed co-morbid conditions to be counted.

Most general hospitals and other health care facilities offer physical rehabilitation services such as physical therapy, occupational therapy, speech therapy, or occupational therapy without the involvement of a formal interdisciplinary program. In addition, some hospitals have consolidated their rehabilitation services into a single unit to improve the coordination of care for acute patients in their facilities. These consolidations are intended to improve the quality of care for patients currently being treated in the facility and are not considered to be providing comprehensive physical rehabilitation services as defined in this section of the Plan.

The following rehabilitation programs are currently available:

Region	Facility	County	Beds	2010 Occupancy	
I	AnMed Health Rehab	Anderson	55	92.1%	*1*
I	Roger C. Peace	Greenville	53	58.4%	
I	St. Francis	Greenville	19	86.7%	
I	Mary Black	Spartanburg	18	58.7%	
I	Spartanburg Rehab	Spartanburg	28	---	*2*
II	Greenwood Rehab Hosp	Greenwood	42	84.2%	*3*
II	HealthSouth Columbia	Richland	96	59.0%	
II	HealthSouth Rock Hill	York	50	80.8%	*4*
III	HealthSouth Florence	Florence	88	49.1%	
III	Carolinas Hospital	Florence	42	69.1%	
III	Waccamaw Community	Georgetown	43	85.5%	
IV	Beaufort Memorial	Beaufort	14	52.2%	
IV	PACE Healthcare	Beaufort	10	---	*5*
IV	HealthSouth Charleston	Charleston	49	79.1%	*6*
IV	Roper Hospital	Charleston	52	74.0%	
IV	RMC-Orangeburg/Calhoun	Orangeburg	24	76.6%	

IV	Coastal Carolina Med Ctr.	Jasper	(0)	0.7%	*7*
		Total	683	68.4%	

1 CON issued 9/22/11 to add 10 rehab beds for a total of 55, SC-11-42. Licensed for 55 beds 1/10/12.
2 CON approved for a 28 bed rehab facility; appealed.
3 CON issued 7/29/11 to add 8 rehab beds for a total of 42 rehab beds, SC-11-27.
4 CON issued 9/22/11 to add 4 rehab beds for a total of 50, SC-11-41. Licensed for 50 rehab beds 2/9/12.
5 CON issued 1/30/12 to establish a 10 bed rehabilitation hospital, SC-12-04.
6 CON issued 9/22/11 to add 3 rehab beds for a total of 49, SC-11-43. Licensed for 49 beds 3/7/12.
7 CON issued 1/31/11 to convert the 10 rehabilitation beds to general acute beds, SC-11-04. Rehabilitation beds were de-licensed 4/5/11.

Certificate of Need Standards

1. The need for beds is calculated based on rehabilitation service areas.

2. The methodology takes the greater of the actual utilization of the facilities in the service area or the statewide average number of beds per 1,000 population to project need.

3. For service areas without existing rehabilitation units and related utilization data, 75% of the overall state use rate was used in the projections.

Quality

CMS has identified two quality measures that inpatient rehabilitation facilities must begin reporting. The data collection starts October 1, 2012 and must be used for all Medicare patients admitted on or after that date. Facilities that fail to comply face a two percent reduction in their reimbursement starting in FY 2014. The quality measures are the number of catheter-associated urinary-tract infections and the percentage of patients with new or worsened pressure ulcers. CMS is considering additional measures to be incorporated later.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);

d. Projected Revenues;
e. Projected Expenses;
f. Cost Containment; and
g. Resource Availability.

Rehabilitation facilities are now located throughout the state and are available within approximately sixty (60) minutes travel time for the majority of residents. Such facilities should be located where an extensive variety of health care professionals are available. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

Statewide Programs

The S.C. Vocational Rehabilitation Center operates a 30-bed facility in West Columbia to serve the vocational training needs of the disabled.

REHABILITATION BED NEED

SERVICE AREA	2010 POP	2017 POP	EXIST BEDS	2010 PDS	PROJ ADC	% OCC	BED NEED (USE)	+/-	BED NEED (SW)	+/-	NEED
ANDERSON,OCONEE	261,399	279,800	55	14,628	42.90	0.70	61	6	32	-23	6
GREENVILLE,PICKENS	570,449	617,100	72	17,304	51.29	0.70	73	1	70	-2	1
CHEROKEE,SPARTANBURG UNION	368,610	391,600	46	3,857	11.23	0.70	16	-30	44	-2	-1
CHESTER,LANCASTER YORK	335,865	365,600	50	13,389	39.93	0.70	57	7	41	-9	7
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	218,708	233,100	42	10,446	30.50	0.70	44	2	26	-16	2
FAIRFIELD,LEXINGTON NEWBERRY,RICHLAND	708,359	760,900	96	20,663	60.81	0.70	87	-9	86	-10	-9
CHESTERFIELD,DARLINGTON DILLON,FLORENCE,MARION MARLBORO,WILLIAMSBURG	380,780	390,900	130	26,378	74.19	0.70	106	-24	44	-86	-24
CLARENDON,KERSHAW LEE,SUMTER	223,344	236,300	0	0	0.00	0.70	0	0	27	27	27
GEORGETOWN,HORRY	329,449	369,600	43	13,417	41.24	0.70	59	16	42	-1	16
AIKEN,ALLENDALE,BAMBERG BARNWELL,CALHOUN ORANGEBURG	316,802	336,600	24	6,706	19.52	0.70	28	4	38	14	14
BEAUFORT,HAMPTON,JASPER	208,100	231,800	24	2,694	8.22	0.70	12	-12	26	2	2
BERKELEY,CHARLESTON COLLETON,DORCHESTER	703,499	745,500	101	27,318	79.31	0.70	113	12	84	-17	12
STATE TOTAL	4,625,364	4,958,800	683	156,800	459.1		656	-27	561	-122	53
			0.1132								

CHAPTER VI

Alcohol and Drug Abuse Facilities

There are six types of licensed substance abuse treatment facilities in South Carolina. These are: outpatient facilities; social detoxification centers; freestanding medical detoxification facilities; residential treatment programs; inpatient treatment services, and narcotic treatment programs. These are defined as follows:

A. Outpatient Facilities:

Outpatient facilities provide treatment/care/services to individuals dependent upon or addicted to psychoactive substances and their families based on an individual treatment plan in a nonresidential setting. Outpatient treatment/care/services include assessment, diagnosis, individual and group counseling, family counseling, case management, crisis management services, and referral. Outpatient services are designed to treat the individual's level of problem severity and to achieve permanent changes in his or her behavior relative to the alcohol/drug abuse. These services address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of treatment or the individual's ability to cope with major life tasks without the non-medical use of alcohol or other drugs. The length and intensity of outpatient treatment varies according to the severity of the individual's illness and response to treatment. There are currently 72 licensed "Outpatient Facilities that Treat Individuals for Psychoactive Substance Abuse or Dependence" in South Carolina, with a total of 98 locations.

Certificate of Need Standards

A Certificate of Need is not required for outpatient facilities as described above.

B. Social Detoxification Facilities:

A service providing supervised withdrawal from alcohol or other drugs in which neither the client's level of intoxification nor physical condition is severe enough to warrant direct medical supervision or the use of medications to assist in withdrawal, but which maintains medical backup and provides a structured program of counseling, if appropriate, educational services, and referral for further rehabilitation. A social detoxification facility provides 24-hour-a-day observation of the client until discharge. Appropriate admission to a social detoxification facility shall be determined by a licensed or certified counselor and subsequently shall be authorized by a physician or other authorized healthcare provider in accordance with Section 1001.A. of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence. The services provided by Social detoxification facilities are described in Section 3102 of Regulation 61-93.

Certificate of Need Standards

A Certificate of Need is not required for a social detoxification facility.

C. Freestanding Medical Detoxification Facilities:

A short-term residential facility, separated from an inpatient treatment facility, providing for medically supervised withdrawal from psychoactive substance-induced intoxification, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse, a structured program of counseling, if appropriate, and referral for further rehabilitation. Appropriate admission to a medical detoxification facility shall be determined by a licensed or certified counselor and subsequently should be authorized by a physician or other authorized healthcare provider in accordance with Section 1001.A. of Regulation 61-93. The services provided by these facilities are described in Section 3101 of the Regulation. Detoxification facilities are envisioned as being physically distinct from inpatient treatment facilities, although there are no prohibitions against an inpatient facility providing detoxification services to its clients as needed.

Morris Village, Patrick Harris, Byrnes Clinical, Holmesview and Palmetto Center are classified as statewide facilities with restricted admissions procedures and are not included in the inventory of facilities.

Facility	County	Beds
Charleston Center Subacute Detoxification Program	Charleston	16
The Phoenix Center Behavioral Health Services	Greenville	16
Lexington/Richland Alcohol & Drug Abuse/Detox Unit	Richland	16
Keystone Inpatient Services	York	10
Statewide Total		58

Certificate of Need Standards

1. Medical detoxification services are allocated by service area.

2. Facilities can be licensed for a maximum of 16 beds in order to meet federal requirements.

3. Because a minimum of 10 beds is needed for a medical detoxification program, a 10 bed unit may be approved in any service area without an existing detoxification unit, provided the applicant can document the need.

Relative Importance of Project Review Criteria

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

1. Compliance with the Need Outlined in this Section of the Plan;
2. Distribution (Accessibility);
3. Projected Revenues;
4. Projected Expenses;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

Currently four freestanding medical detoxification facilities are located in the state, operated by local County Alcohol and Drug Abuse Agencies. There is a projected need for beds in almost every service area. Additional facilities are needed for the services to be accessible within sixty (60) minutes travel time for the majority of state residents. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

D. Residential Treatment Program Facilities:

RTPFs are 24-hour facilities offering an organized service in a residential setting, which is designed to improve the client's ability to structure and organize the tasks of daily living and recovery through planned clinical activities, counseling, and clinical monitoring in order to promote successful involvement or re-involvement in regular, productive, daily activity, and, as indicated, successful reintegration into family living. Residential treatment programs utilize a multi-disciplinary staff for clients whose biomedical and emotional/behavioral problems are severe enough to require residential services and who are in need of a stable and supportive environment to aid in their recovery and transition back into the community. Twenty-four hour observation, monitoring, and treatment shall be available.

Residential treatment programs provide the services described in Section 3000 of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

Certificate of Need Standards

A Certificate of Need is not required for a Residential Treatment Program.

E. Inpatient Treatment Facilities:

This is a short-term treatment service for persons who are in need of an organized intensive program of alcohol and/or drug rehabilitation, but who are without serious debilitating medical complications. These facilities may provide detoxification for their patients, as needed, in the inpatient treatment beds. These facilities are licensed either as a specialized hospital or as part of a hospital. Inpatient treatment facilities must comply with either Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence or Regulation 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries.

Region	Facility	County	Beds	2010 Occupancy	
I	Carolina Center Behavioral Health	Greenville	21	119.3%	*1*
I	Holmesview Center (Statewide)	Greenville	44	-----	*2*
II	Self Regional Healthcare	Greenwood	24	0.0%	
II	Springs Memorial	Lancaster	18	0.0%	*3*
II	Three Rivers Behavioral Health	Lexington	17	63.3%	
II	Morris Village (Statewide)	Richland	163	68.6%	*2*
II	Palmetto Health Baptist	Richland	10	0.0%	
II	Palmetto Richland Springs	Richland	10	93.7%	
II	William S. Hall (Statewide)	Richland	19	77.9%	*2*
III	Carolinas Hospital System	Florence	12	41.9%	
III	Palmetto Center (Statewide)	Florence	48	-----	*2*
III	Lighthouse Care Center Conway	Horry	14	97.5%	*4*
IV	Aiken Regional Medical Center	Aiken	18	94.1%	
IV	Medical University	Charleston	23	43.1%	
IV	Palmetto Lowcountry Behavioral	Charleston	10	126.5%	
IV	[William J. McCord (Statewide)]	Orangeburg	(0)	98.1%	*5*
	Total (Does Not Include Statewide Beds)		177	53.8%	

1 CON issued 4/26/12 to add 8 beds for a total of 21.

2 Not Included in Bed Need Calculations.

3 CON approved 8/22/08 to convert the 18 substance abuse beds to general beds. However, it was appealed and the applicant withdrew the proposal.

4 CON issued 1/25/10 for 6 additional beds for a total of 14.

5 CON issued 7/16/10 to re-classify William J. McCord Adolescent Treatment Facility as a specialized hospital with 15 psychiatric beds restricted for the primary purpose of providing alcohol and drug services to adolescents. These beds are no longer classified as inpatient substance abuse treatment beds.

Morris Village, Holmesview, Palmetto Center and William S. Hall are classified as statewide facilities with restricted admissions procedures and are not included in the inventory of facilities and need calculations.

Certificate of Need Standards

1. Need projections are calculated by service area.

2. The bed need methodology takes the greater of the actual utilization of the facilities in the service area or the statewide beds per 1,000 population to project need.

3. For service areas without existing psychiatric units and related utilization data, the state use rate was used in the projections.

4. Because a minimum of 10 beds is needed for an inpatient program, a 10-bed unit may be approved in an area that does not have any existing beds provided the applicant can document the need.

5. Inpatient treatment facilities are physically distinct from freestanding detoxification centers. Applicants may not combine the bed need for freestanding detoxification with the bed need for inpatient treatment in order to generate a higher bed need for an inpatient facility. There are no prohibitions against an inpatient facility providing detoxification services to its clients as needed, but the bed need projections refer to two distinct treatment modes that cannot be commingled.

6. The establishment of a regional treatment center that serves more than a single service area may be proposed in order to improve access to care for patients in service areas that do not currently have such services available. Such a proposed center would be allowed to combine the bed need for a service area without existing services with another service area providing this other service area shows a need for additional beds. The applicant must document with patient origin data the historical utilization of the residents in the service area that is to be combined, or why it is in the best interest of these residents for their projected bed need to be used to used to form a regional treatment facility.

7. It is frequently impossible for a facility to totally predict or control short-term deviation in the number of patients with mixed psychiatric/addictive etiology to their illnesses. Therefore, in the case of facilities with licensed beds for both psychiatric and substance abuse treatment, the Department will allow deviations of up to 25% of the total number of licensed beds as swing beds to accommodate patients having diagnoses of both psychiatric and substance abuse disorders.

Relative Importance of Project Review Criteria

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

1. Compliance with the Need Outlined in this Section of the Plan;

INPATIENT BED NEED

SERVICE AREA	2010 POP	2017 POP	EXIST BEDS	2010 PAT DAYS	PROJ ADC	% OCCUP	BED NEED (USE)	+/-	BED NEED (SW)	+/-	NEED
ANDERSON,OCONEE	200,867	217,900	0	0	0.00	0.70	0	0	8	8	8
GREENVILLE,PICKENS	436,845	479,500	21	5,660	17.02	0.70	24	3	18	-3	3
CHEROKEE,SPARTANBURG,UNION	278,906	300,100	0	0	11.29	0.70	16	16	11	11	16
CHESTER,LANCASTER,YORK	252,362	280,300	18	0	0.00	0.70	0	-18	11	-7	-7
ABBEVILLE,EDGEFIELD,GREENWOOD, LAURENS,MCCORMICK,SALUDA	169,153	184,100	24	0	6.92	0.70	10	-14	7	-17	-14
FAIRFIELD,KERSHAW,LEXINGTON, NEWBERRY,RICHLAND	589,227	641,100	37	7,347	21.90	0.70	31	-6	24	-13	-6
DARLINGTON,FLORENCE,MARION	180,199	189,800	12	1,837	5.30	0.70	8	-4	7	-5	-4
CHESTERFIELD,DILLON,MARLBORO	81,275	82,900	0	0	3.12	0.70	4	4	3	3	4
CLARENDON,LEE,SUMTER	122,144	128,900	0	0	4.85	0.70	7	7	5	5	7
GEORGETOWN,HORRY,WILLIAMSBURG	288,488	328,600	14	2,847	12.36	0.70	18	4	12	-2	4
BAMBERG,CALHOUN,ORANGEBURG	95,356	99,800	0	0	3.75	0.70	5	5	4	4	5
ALLENDALE,BEAUFORT,HAMPTON, JASPER	170,616	196,300	0	0	7.38	0.70	11	11	7	7	11
BERKELEY,CHARLESTON,COLLETON DORCHESTER	539,361	574,900	33	8,229	24.03	0.70	34	1	22	-11	1
AIKEN,BARNWELL	140,094	155,100	18	6,184	18.76	0.70	27	9	6	-12	9
STATE TOTAL	3,544,893	3,859,300	177	32,104	136.68		195	18	147	-30	37
	0.013726		0.0459								

2. Distribution (Accessibility);
3. Projected Revenues;
4. Projected Expenses;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

Currently, 11 inpatient treatment facilities are located in the state, not including state-operated facilities. There is a projected need for additional beds in some service areas. Services are accessible within sixty (60) minutes travel time for the majority of residents of the state. Current utilization and population growth are factored into the methodology for determining the need for additional beds. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

F. Narcotic Treatment Programs:

Note: Narcotic treatment programs were added back under CON review by the General Assembly in 2011 after being removed during the 2010 CON law revisions.

Narcotic treatment programs provide medications for the rehabilitation of persons dependent on opium, morphine, heroin or any derivative or synthetic drug of that group. Opioid maintenance therapy (OMT) is an umbrella term that encompasses a variety of pharmacologic and nonpharmacologic treatment modalities, including the therapeutic use of specialized opioid compounds such as methadone, suboxone and buprenorphine to psychopharmacologically occupy opiate receptors in the brain, extinguish drug craving and thus establish a maintenance state. OMT is a separate service that can be provided in any level of care, as determined by the client's needs. Adjunctive nonpharmacologic interventions are essential and may be provided in the OMT clinic or through coordination with another addiction treatment provider. Narcotic treatment programs are described in Section 3200 of Regulation Number 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

An average charge for medication would be approximately $12 per day or $70 per week. In South Carolina a Registered Pharmacist must dispense the medication. Therefore, because of the staffing and associated costs with providing this care, it requires providers to have a minimum caseload of around 150 clients to break even on the costs of providing this service.

There are currently 15 licensed programs in the state:

Region	Facility	County
I	Southwest Carolina Treatment Center	Anderson
I	Crossroads Treatment Center of Greenville	Greenville
I	Greenville Metro Treatment Center	Greenville
I	Recovery Concepts of the Carolina Upstate	Pickens

I	Spartanburg Treatment Associates	Spartanburg
II	Columbia Metro Treatment Center	Lexington
II	Crossroads Treatment Center of Columbia	Richland
II	York County Treatment Center	York
III	Starting Point of Darlington	Darlington
III	Starting Point of Florence	Florence
III	Center of Hope Myrtle Beach	Horry
IV	Aiken Treatment Specialists	Aiken
IV	Center for Behavioral Health South Carolina	Charleston
IV	Recovery Concepts	Jasper

Certificate of Need Standards

1. A Certificate of Need is required for a narcotic treatment program.

2. An applicant must project a minimum caseload of 150 clients.

3. According to the licensing standards, a narcotic treatment program shall not operate within 500 feet of: a church, a public or private elementary or secondary school, a boundary of any residential district, a public park adjacent to any residential district, or the property line of a lot devoted to residential use. The minimum 500 feet should be measured from any point of the property line.

4. Because clients must usually attend a center 6 days per week to receive their dose of medication, these centers should be located throughout the state. Narcotic treatment programs should be developed in counties where none exists to improve accessibility. An additional treatment program can only be approved in counties where an existing program exists if the applicant is able to document that the existing program has a sufficient waiting list for admission that would justify the need for an additional program.

Relative Importance of Project Review Criteria

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with this Plan;
b. Distribution (Accessibility);
c. Record of the Applicant;
d. Ability of the Applicant to Complete the Project.

The benefits of improved accessibility will not outweigh the adverse effects of the duplication of this existing service.

CHAPTER VII

RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS

A Residential Treatment Facility for Children and Adolescents is operated for the assessment, diagnosis, treatment, and care of children and adolescents in need of mental health treatment. This means a child or adolescent up to age 21 who manifests a substantial disorder of cognitive or emotional process, which lessens or impairs to a marked degree that child's capacity either to develop or to exercise age-appropriate or age-adequate behavior. The behavior includes, but is not limited to, marked disorders of mood or thought processes, severe difficulties with self-control and judgment, including behavior dangerous to self or others, and serious disturbances in the ability to care for and relate to others.

These facilities provide medium to long-term care (6 months or longer). Treatment modalities are both medical and behavioral in nature. Some facilities contract with the Continuum of Care for Emotionally Disturbed Children to provide these services. The following facilities are currently licensed or approved as Residential Treatment Facilities:

Region	Facility	County	Beds	FY 2010 Occ. Rate	
I	Excalibur Youth Services	Greenville	60	54.5%	
I	Generations	Greenville	30	---	*1*
I	Marshall Pickens	Greenville	22	96.4%	
I	Springbrook Behavioral	Greenville	68	81.7%	
I	Avalonia Group Homes	Pickens	55	65.1%	
II	Three Rivers Behavioral	Lexington	20	77.1%	
II	Three Rivers – Midlands	Lexington	59	86.8%	
II	Carolina Children's Home	Richland	30	72.1%	*2*
II	Directions (DMH)	Richland	37	51.0%	
II	New Hope Carolinas	York	150	87.9%	
II	York Place Episcopal	York	40	67.7%	
III	Palmetto Pee Dee	Florence	59	99.5%	
III	Lighthouse of Conway	Horry	30	68.7%	
III	Willowglen Academy	Williamsburg	40 (54)	39.9%	*3*
IV	Palmetto Low Country	Charleston	32	101.2%	
IV	Riverside at Windwood	Charleston	12	88.7%	*4*
IV	Palmetto Pines Behavioral	Dorchester	60	98.0%	
IV	Pinelands RTC	Dorchester	14 (28)	26.0%	*5*
	Total (Does Not Include Directions)		781 (809)	82.3%	

1 Exempted to convert from a Group Home to an RTF. Licensed 8/25/11.

2 Licensed for 20 RTF beds 6/16/09; licensed 10 additional beds for a total of 30, 1/20/11.
3 Licensed for 40 beds 3/20/09; intend to license 54 total beds.
4 Licensed 3/18/10.
5 Licensed for 14 beds 7/21/10; intend to license 28 total beds.

Services available at a minimum should include the following:

1. 24-hour, awake supervision in a secure facility;

2. Individual treatment plans to assess the problems and determine specific patient goals;

3. Psychiatric consultation and professional psychological services for treatment supervision and consultation;

4. Nursing services, as required;

5. Regularly scheduled individual, group, and/or family counseling in keeping with the needs of each client;

6. Recreational facilities with an organized youth development program;

7. A special education program with a minimum program defined by the South Carolina Department of Education; and

8. Discharge planning including a final assessment of the patient's condition and an aftercare plan indicating any referrals to follow-up treatment and self-help groups.

Each facility shall have a written plan for cooperation with other public and private organizations, such as schools, social service agencies, etc., to ensure that each child under its care will receive comprehensive treatment. In addition, each facility shall have a written transfer agreement with one or more hospitals for the transfer of emergency cases when such hospitalization becomes necessary.

A proposal for Residential Treatment Facilities for Children and Adolescents should have letters of support from the Continuum of Care for Emotionally Disturbed Children, the SC Department of Social Services and the SC Department of Mental Health. Priority consideration will be given to those facilities that propose to serve highly aggressive and sexual offending youths and those with other needs as determined by these State agencies. In addition, smaller facilities may be given greater consideration than large facilities based on recommendations from the above agencies.

Certificate of Need Standards

1. Except in the case of high management group homes that received exemption from CON through Health and Human Services Budget Proviso 8.35, the establishment or expansion of an RTF requires a CON.

2. The applicant must document the need for the expansion of or the addition of an RTF based on the most current utilization data available. The existing resources must be considered and documentation presented as to why these resources are not adequate to meet the needs of the community.

3. For a new facility, the applicant must document where the potential patients for the facility will come from and where they are currently being served, to include the expected shift in patient volume from existing providers. For the expansion of an existing facility, the applicant must provide patient origin information on the current facility.

4. The applicant must document the potential impact that the proposed new RTF or expansion will have upon the existing service providers and referral patterns.

5. The applicant must provide a written commitment that the facility will provide services for indigent and charity patients at a percentage that is comparable to other health care facilities in the service area.

6. The applicant agrees to provide utilization data on the operation of the facility to the Department.

The bed need methodology to be used in South Carolina is based upon a standard of 41.4 beds per 100,000 children. Since few, if any, children under 5 years of age would be candidates for this type of care, the bed need will be based on the population age 5-21. The projected bed needs by service area are as follows:

Inventory Region I (Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, Union).

Facilities:	Avalonia Group Homes	55 beds
	Excalibur Youth Services	60
	Generations – Bridges	10
	Generations – Horizons	20
	Marshall Pickens	22
	Springbrook Behavioral	68
	Total	235 beds

2017 Population Age 5-21:	288,800
41.4 Beds/100,000 Population:	x .000414
	120 beds
	- 235 beds
Need Shown:	(115) beds

Inventory Region II Abbeville, Chester, Edgefield, Fairfield, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Richland, Saluda, York.

Facilities:		
	Carolina Children's Home	30 beds
	New Hope Carolinas	150
	Three Rivers Behavioral	20
	Three Rivers – Midlands	59
	York Place	40
	Total	299 beds

2017 Population Age 5-21:	320,000
41.4 Beds/100,000 Population:	x .000414
	133 beds
	- 299 beds
Need Shown:	(166) beds

Inventory Region III Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg.

Facilities:		
	Lighthouse of Conway	30 beds
	Palmetto Pee Dee	59
	Willowglen Academy	54
	Total	143 beds

2017 Population Age 5-21:	192,300
41.4 Beds/100,000 Population:	x .000414
	80 beds
	- 143 beds
Need Shown:	(63) beds

Inventory Region IV	Aiken, Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg.	
Facilities:	Palmetto Low Country	32 beds
	Palmetto Pines Behavioral	60
	Pinelands RTC	28
	Riverside at Windwood	12
	Total	132 beds

2017 Population Age 5-21:	274,100
41.4 Beds/100,000 Population:	x .000414
	114 beds
	- 132 beds
Need Shown:	(18) beds

The Directions program primarily serves court-ordered patients from the Department of Juvenile Justice (DJJ). As a statewide facility serving a restricted population, it is not included in the regional inventories for bed need calculations.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Projected Revenues;
d. Projected Expenses;
e. Record of the Applicant;
f. Ability of the Applicant to Complete the Project;
g. Cost Containment; and
h. Staff Resources.

Residential treatment facility beds for children and adolescents are distributed statewide and are located within sixty (60) minutes travel time for the majority of residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CHAPTER VIII

CARDIOVASCULAR CARE

Cardiovascular diseases are the leading cause of death in the United States, accounting for more than 40% of all deaths. The total death rate for all cardiovascular diseases in South Carolina is the second highest in the country. Approximately one-third of all heart attacks are fatal. The amount of heart muscle damaged during a heart attack is an important determinant of whether patients live or die - and what their quality of life will be if they survive.

Diagnostic and therapeutic cardiac catheterizations and open heart surgery are tools in the treatment of heart disease. During a cardiac catheterization, a thin, flexible tube is inserted into a blood vessel in the arm or leg. The physician manipulates the tube to the chambers or vessels of the heart so that pressure measurements, blood samples and photographs can be taken. Injections of contrast material allow blockages or areas of weakness to appear on x-rays. Other diagnostic and therapeutic procedures may also be performed. Diagnostic catheterizations take approximately one and one-half hours to perform, while therapeutic catheterizations average three hours.

Percutaneous Coronary Interventions (PCIs) are therapeutic catheterization procedures used to revascularize occluded or partially occluded coronary arteries. These interventions include, but are not limited to: bare and drug-eluting stent implantation; Percutaneous Transluminal Coronary Angioplasty (PTCA); cutting balloon atherectomy; rotational atherectomy; directional atherectomy; excimer laser angioplasty; and extractional thrombectomy.

These procedures may be performed on an emergent or elective basis. "Emergent or Primary" means that a patient needs immediate PCI because, in the treating physician's best clinical judgment, delay would result in undue harm or risk to the patient. An "Elective" PCI is scheduled in advance and performed on a patient with cardiac function that has been stable in the days prior to the procedure.

In 2011, the American College of Cardiology (ACC) and American Heart Association (AHA) revised their Guidelines for PCI. The previous version of the Guidelines allowed the provision of Emergent/Primary PCIs in hospitals without an on-site open heart surgery program if certain criteria could be met, but, due to the risk of arterial damage and the resulting need for immediate open heart surgery, elective PCI was contraindicated for institutions without on-site surgical backup. The new Guidelines state that:

> Elective PCI might be considered in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished and rigorous clinical and angiographic criteria are used for proper patient selection...Primary or elective PCI should not be performed in hospitals without on-site cardiac surgery capabilities without a proven plan for rapid transport to a cardiac surgery operating room in a nearby hospital or without appropriate hemodynamic support capability for transfer.

Hospitals without an open heart surgery program shall be allowed to establish comprehensive cardiac catheterization laboratories to provide both Emergent/Primary and Elective PCIs only if they comply with all sections of Standard (8) of the Standards for Cardiac Catheterization.

Open heart surgery or cardiac surgery refers to an operation performed on the heart or intrathoracic great vessels. Coronary Artery Bypass Graft (CABG) accounts for 80-85% of all open heart surgery cases, where veins are extracted from the patient and grafted to bypass a constricted section of coronary artery. The thoracic cavity is opened to expose the heart, which is stopped and the blood is recirculated and oxygenated during surgery by a heart-lung machine. Another option is "beating heart surgery," like Minimally Invasive Direct Coronary Artery Bypass (MIDCAB), where the surgeon operates through a smaller incision rather than breaking the breastbone to open the chest cavity and no bypass machine is used. The success rate for CABG surgery is high; the American Heart Association reports that 90% of bypass grafts still work 10 years after they are put into place. The mortality rate continues to decline, but CABG still carries significant risks.

Both cardiac catheterization and open heart surgery programs require highly skilled staffs and expensive equipment. Appropriately equipped and staffed programs serving larger populations are preferable to multiple, minimum population programs. Underutilized programs may reflect unnecessary duplication of services in an area, which may seriously compromise quality and safety of procedures and increase the cost of care. Optimal performance requires a caseload of adequate size to maintain the skills and efficiency of the staff. Cardiac catheterization laboratories should perform a minimum of 600 diagnostic equivalents per year (diagnostic catheterizations are weighted as 1.0 equivalents, therapeutic catheterizations as 2.0). Emergent PCI providers should perform a minimum of 36 PCIs annually; all other therapeutic cath providers should perform a minimum of 300 therapeutic caths annually. For pediatric catheterization and adult congenital cath labs, diagnostic catheterizations are weighted as 2.0 equivalents, therapeutic catheterizations as 3.0, EP studies as 2.0, biopsies performed after heart transplants as 1.0 equivalents, and adult concomitant congenital heart disease procedures performed in these labs are included in the utilization calculations. A minimum of 150 procedures per year is recommended; half of these should be on neonates or infants. There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit; improved results appear to appear in hospitals that perform a minimum of 350 cases annually. Pediatric open heart surgery units should perform 100 pediatric heart operations per year, at least 75 of which should be open heart surgery.

A. Status of South Carolina Providers:

1. Cardiac Catheterizations:

The Certificate of Need standards for cardiac catheterization require a minimum of 600 cardiac equivalents per laboratory annually within 3 years of initiation of service. There are 32 facilities approved to provide cardiac catheterization services in fixed laboratories in South Carolina. Please note that in the spreadsheet of cardiac cath lab utilization, the columns showing the 2008 through 2010 total caths are now reported in cardiac equivalents rather than summing the number of diagnostic and therapeutic caths performed. Therefore, the 2008 and 2009 totals are not comparable

to those reported in the previous Plan, but this modification gives a more accurate accounting of the total cath lab utilization for each facility.

Of the 31 facilities that have been offering cardiac caths for more than three years, 19 exceeded the minimum of 600 equivalents per lab in 2010. Carolina Pines Regional Medical Center failed to report 2010 utilization. Baptist Easley Hospital, Beaufort Memorial, Bon Secours St. Francis Xavier, Hilton Head Hospital, KershawHealth, Loris Community Hospital, Mary Black Memorial, Palmetto Health Baptist, Regional Medical Center–Orangeburg/Calhoun, Springs Memorial, and Tuomey Hospital fell below the minimum. Village Hospital was approved for a diagnostic cath lab in November 2010. There are two mobile cath labs approved in the state, at Colleton Medical Center and Chester Regional Medical Center. The number of diagnostic catheterizations performed statewide decreased from 37,813 in 2009 to 34,536 in 2010.

Seventeen hospitals with open heart surgery programs provide therapeutic caths. They should be performing a minimum of 300 therapeutic caths annually within three years of initiation of service. Of the programs that had been operational for three full years, all but Aiken Regional Medical Center, Carolinas Hospital System, and Hilton Head Regional Medical Center performed the minimum number in 2010. In addition, Baptist Easley Hospital and Georgetown Memorial Hospital have received CONs to perform Emergent PCIs without open heart surgery back-up. Lexington Medical Center received a CON to perform Emergent PCIs without open heart surgery back-up in 2009, but then established comprehensive cath services through the transfer of an open heart surgery suite from Providence Hospital in 2010. The number of therapeutic catheterizations performed statewide decreased from 15,903 in 2009 to 15,684 in 2010.

MUSC is the only facility providing pediatric cardiac catheterizations in South Carolina. The standard recommends a minimum of 600 cardiac equivalents per year; MUSC performed 1,421 equivalents in 2010.

2. Open Heart Surgery:

Currently 17 open heart surgery programs have been approved for the general public in South Carolina, in addition to the Veterans Administration (VA) Hospital in Charleston. Lexington Medical Center received a CON on 6/18/10 to establish open heart surgery services through the relocation of one open heart surgery suite from Providence Hospital. They expect to start performing surgeries in 2012. The number of open heart surgeries performed decreased from 5,053 in 2009 to 4,870 in 2010. A total of 35 open heart surgery suites were in operation in 2010. With a capacity of 500 surgeries per suite, the statewide capacity was 17,500 surgeries. The state average utilization rate of 27.8% equated to 139.1 surgeries per suite. Unused capacity remains in all programs in the state.

The Certificate of Need standard is for a facility to perform a minimum of 200 open heart surgeries per year per surgical suite within three years of initiation of service. Only Spartanburg Regional, Providence Hospital and Roper Hospital averaged at least 200 open heart surgeries per suite in 2010. Grand Strand Regional (194.5), Palmetto Health Richland (192.0), St. Francis-Downtown (190.5) and Trident Medical Center (189.0) came close to meeting this standard. Studies indicate that

hospitals that perform a minimum of 350 total cases annually tend to have better outcomes than those that perform fewer cases. In 2010, only eight of the 16 existing programs performed more than 350 total surgeries.

MUSC is the only facility performing pediatric open heart surgery in South Carolina. National and state standards recommend a minimum of 100 pediatric heart operations per open heart surgical suite. MUSC has consistently exceeded this standard; in 2010, 210 pediatric open heart surgeries were performed there.

The Certificate of Need standards for Cardiac Catheterization and Open Heart Surgery follow.

B. Cardiac Catheterization:

1. Definitions:

"Cardiac Catheterization Procedure" is an invasive procedure where a thin, flexible catheter is inserted into a blood vessel; the physician then manipulates the free end of the catheter into the chambers or vessels of the heart. All activities performed during one clinical session, including angiocardiography, coronary arteriography, pulmonary arteriography, coronary angioplasty and other diagnostic or therapeutic measures and physiologic studies shall be considered one procedure.

"Comprehensive Catheterization Laboratory" means a dedicated room or suite of rooms in which both diagnostic and therapeutic catheterizations are performed, either with or without on-site open heart surgery backup.

"Diagnostic Catheterization" refers to a cardiac catheterization during which any or all of the following diagnostic procedures or measures are performed: Blood Pressure; Oxygen Content and Flow Measurements; Angiocardiography, Coronary Arteriography; and Pulmonary Arteriography. The following ICD-9-CM Procedure Codes refer to diagnostic catheterizations:

37.21 Right Heart Cardiac Catheterization
37.22 Left Heart Cardiac Catheterization
37.23 Combined Right and Left Heart Cardiac Catheterization

"Diagnostic Catheterization Laboratory" means a dedicated room in which only diagnostic catheterizations are performed.

"Diagnostic Equivalents" are the measurements of capacity and utilization for cardiac catheterization laboratories. For adult labs, diagnostic catheterizations are weighted as 1.0 equivalents and therapeutic caths are weighted as 2.0 equivalents. For pediatric catheterization and adult congenital cath labs, diagnostic catheterizations are weighted as 2.0 equivalents, therapeutic catheterizations as 3.0, EP studies as 2.0, and biopsies performed after heart transplants as 1.0 equivalents.

"Percutaneous Coronary Intervention (PCI)" refers to a therapeutic procedure to relieve coronary narrowing, such as Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Stent Implantation. These procedures may be performed on an emergent or elective basis. "Emergent or Primary" means that a patient needs immediate PCI because, in the treating physician's best clinical judgment, delay would result in undue harm or risk to the patient. An "Elective" PCI is scheduled in advance and performed on a patient with cardiac function that has been stable in the days prior to the procedure.

"Therapeutic catheterization" refers to a PCI or cardiac catheterization during which, in addition to any diagnostic catheterization procedure, any or all of the following interventional procedures are performed: PTCA; Thrombolytic Agent Infusion; Directional Coronary Atherectomy; Rotational Atherectomy; Extraction Atherectomy; Coronary Stent Implants and Cardiac Valvuloplasty. The following ICD-9-CM Procedure Codes refer to therapeutic catheterizations:

00.66 Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Atherectomy
35.52 Repair of Atrial Septal Defect with Prothesis, Closed Technique
35.96 Percutaneous Valvuloplasty
36.06 Insertion of Coronary Artery Stent(s)
36.07 Insertion of Drug Eluting Coronary Artery Stent(s)
36.09 Other Removal of Coronary Artery Obstruction
37.34 Excision or Destruction of Other Lesion or Tissue of Heart, Other Approach

2. Scope of Services:

The following services should be available in both adult and pediatric catheterization laboratories:

A. Each cardiac catheterization lab should be competent to provide a range of angiographic (angiocardiography, coronary arteriography, pulmonary arteriography), hemodynamic, and physiologic (cardiac output measurement, intracardiac pressure, etc.) studies. These facilities should be available in one laboratory so that the patient need not be moved during a procedure.

B. The lab should have the capability of immediate endocardiac catheter pacemaking in cardiac arrest, a crash cart, and defibrillator.

C. A full range of non-invasive cardiac/circulatory diagnostic support services, such as the following, should be available within the hospital:

1. Nuclear Cardiology
2. Echocardiography
3. Pulmonary Function Testing
4. Exercise Testing
5. Electrocardiography
6. Cardiac Chest X-ray and Cardiac Fluoroscopy
7. Clinical Pathology and Blood Chemistry Analysis
8. Phonocardiography
9. Coronary Care Units (CCUs)
10. Medical Telemetry/Progressive Care

D. Each applicant shall document plans for providing cardiac rehabilitation services to its patients or plans for establishing referral agreements with facilities offering cardiac rehabilitation services.

Cardiac catheterization studies for elective cases should be available at least 40 hours a week. All catheterization laboratories should have the capacity for rapid mobilization of the study team for emergency procedures 24 hours a day, 7 days a week. All facilities offering cardiac catheterization

services should meet full accreditation standards for The Joint Commission (TJC) or similar accrediting body.

Certificate of Need Standards

1. The capacity of a fixed cardiac catheterization laboratory shall be 1,200 diagnostic equivalents per year. Adult diagnostic catheterizations (ICD-9-CM Procedure Codes 37.21, 37.22 and 37.23) shall be weighted as 1.0 equivalents, while therapeutic catheterizations (ICD-9-CM Procedure Codes 00.66, 35.52, 35.96, 36.06, 36.07, 36.09, and 37.34) shall be weighted as 2.0 equivalents. For pediatric and adult congenital cath labs, diagnostic caths shall be weighted as 2.0 equivalents, therapeutic caths shall be weighted as 3.0 equivalents, electrophysiology (EP) studies shall be weighted as 2.0 equivalents, and biopsies performed after heart transplants shall be weighted as 1.0 equivalents. The capacity of mobile cardiac catheterization labs will be calculated based on the number of days of operation per week.

2. The service area for a diagnostic catheterization laboratory is defined as all facilities within 45 minutes one way automobile travel time; for comprehensive cardiac catheterization laboratories the service area is all facilities within 60 minutes one way automobile travel time; a pediatric cardiac program should serve a population encompassing at least 30,000 births per year, or roughly two million people.

3. New diagnostic cardiac catheterization services, including mobile services, shall be approved only if all existing labs in the service area have performed at a combined use rate of 80% (960 equivalents per laboratory) for the most recent year;

4. An applicant for a fixed diagnostic service must project that the proposed service will perform a minimum of 600 diagnostic equivalent procedures annually within three years of initiation of services, without reducing the utilization of the existing diagnostic catheterization services in the service area below 80% of capacity.

5. An applicant for a mobile diagnostic catheterization laboratory must be able to project a minimum of 120 diagnostic equivalents annually for each day of the week that the mobile lab is located at the applicant's facility by the end of the third year following initiation of the service, without reducing the utilization of the existing diagnostic catheterization services in the service area below 80% of capacity (i.e. an applicant wishing to have a mobile cath lab 2 days per week must project a minimum of 240 equivalents at the applicant's facility by the end of the third year of operation). In addition:

   A. The applicant must document that the specific mobile unit utilized by the vendor will perform a combined minimum of 600 diagnostic equivalents per year;

   B. The applicant must include vendor documentation of the complication rate of the mobile units operated by the vendor; and

C. If an application for a mobile lab is approved and the applicant subsequently desires to change vendors, the Department must approve such change in order to insure that appropriate minimum utilization can be documented.

6. Expansion of an existing diagnostic cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (i.e. 960 equivalents per laboratory) for each of the past two years and can project a minimum of 600 procedures per year on the additional equipment within three years of its implementation.

7. In 2011, the ACC/AHA/SCAI Writing Committee determined that primary PCI is reasonable in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished; and elective PCI might be considered in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished and rigorous clinical and angiographic criteria are used for proper patient selection. The provision of PCIs at a hospital, with or without an on-site open heart surgery program, constitutes the establishment of a comprehensive cardiac catheterization laboratory and requires a Certificate of Need. Hospitals with diagnostic laboratories that have been approved to perform primary PCI without on-site open heart surgical backup under the 2005 ACC/AHA Guideline Update for PCI must obtain a Certificate of Need in order to upgrade to designation as comprehensive cardiac catheterization laboratories.

8. New comprehensive cardiac catheterization services shall be approved only if the following conditions are met:

A. The applicant has a diagnostic catheterization laboratory that has performed a minimum of 600 diagnostic catheterizations for the most recent year of data.

B. All existing comprehensive cardiac catheterization facilities in the service area performed a minimum of 300 therapeutic catheterizations and performed at a combined use rate of 80 percent in the most recent year (i.e. 960 equivalents per laboratory); and

C. An applicant must project that the proposed service will perform a minimum of 300 therapeutic catheterization procedures annually within three years of initiation of services, without reducing the combined use rate of the existing comprehensive catheterization programs in the service area below 80%.

D. The physicians must be experienced interventionalists who perform a minimum of 75 elective PCI cases per year and preferably at least 11 PCI procedures for STEMI each year. Ideally, operators with an annual procedure volume of fewer than 75 procedures per year should only work at institutions with an activity level of more than 600 procedures per year. Operators who perform fewer than 75 procedures per year should develop a defined mentoring relationship with a highly experienced operator who has an annual procedural volume of at least 150 procedures.

E. For comprehensive cath labs in facilities without on-site surgical backup, there must be formalized written protocols in place for immediate (within one hour) and efficient transfer of patients to the nearest cardiac surgical facility that are reviewed and tested on a regular basis.

F. The catheterization laboratory must be well-equipped, with optimal imaging systems, resuscitative equipment, intra-aortic balloon pump (IABP) support, and must be well-stocked with a broad array of interventional equipment.

G. The nursing and technical catheterization laboratory staff must be experienced in handling acutely ill patients and comfortable with interventional equipment. They must have acquired experience in dedicated interventional laboratories at a surgical center. They participate in a 24-hour, 365-day call schedule.

H. The cardiac care unit nurses must be adept in hemodynamic monitoring and IABP management.

I. Every therapeutic cath program should operate a quality-improvement program that routinely:

1. reviews quality and outcomes of the entire program;
2. reviews results of individual operators;
3. includes risk adjustment;
4. provides peer review of difficult or complicated cases; and
5. performs random case reviews.

J. Every PCI program should participate in a regional or national PCI registry for the purpose of benchmarking its outcomes against current national norms.

9. Expansion of an existing comprehensive cardiac catheterization service shall be approved only if the service has operated at a minimum use rate of 80% of capacity (960 equivalents per lab) for each of the past two years and can project a minimum of 600 equivalents per year on the additional equipment within three years of its implementation. The 600 equivalents may consist of a combination of diagnostic and therapeutic procedures.

10. New pediatric cardiac catheterization services shall be approved only if the following conditions are met:

A. All existing facilities have performed at a combined use rate of 80% of capacity for the most recent year; and

B. An applicant must project that the proposed service will perform a minimum of 600 diagnostic equivalent procedures annually within three years of initiation of services.

11. Expansion of an existing pediatric cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (960 equivalents) for each of the past two years and can project a minimum of 600 equivalents per year on the additional equipment within three years of its implementation.

12. Documentation of need for the proposed service:

    A. The applicant shall provide epidemiologic evidence of the incidence and prevalence of conditions for which diagnostic, comprehensive or pediatric catheterization is appropriate within the proposed service area, to include the number of potential candidates for these procedures;

    B. The applicant shall project the utilization of the service and the effect of its projected utilization on other cardiac catheterization services within its service area, to include:

        1. The number of patients of the applicant hospital who were referred to other cardiac catheterization services in the preceding three years and the number of those patients who could have been served by the proposed service;

        2. The number of additional patients, if any, who will be generated through changes in referral patterns, recruitment of specific physicians, or other changes in circumstances. The applicant shall document the services, if any, from which these patients will be drawn; and

        3. Existing and projected patient origin information and referral patterns for each cardiac catheterization service serving patients from the area proposed to be served shall be provided.

13. Both fixed and mobile diagnostic cardiac catheterization laboratories must provide a written agreement with at least one hospital providing open heart surgery, which states specified arrangements for referral and transfer of patients, to include:

    A. Criteria for referral of patients on both a routine and an emergency back-up basis;

    B. Regular communications between cardiologists performing catheterizations and surgeons to whom patients are referred;

    C. Acceptability of diagnostic results from the cardiac catheterization service to the receiving surgical service to the greatest extent possible to prevent duplication of services; and

    D. Development of linkages with the receiving institution's peer review mechanism.

14. The application shall include standards adopted or to be adopted by the service, consistent with current medical practice as published by clinical professional organizations, such as the

American College of Cardiology or the American Heart Association, defining high-risk procedures and patients who, because of their conditions, are at high risk. For diagnostic catheterization laboratories, this description of patient selection criteria shall include referral arrangements for high-risk patients. For comprehensive laboratories, these high-risk procedures should only be performed with open heart surgery back-up. The cardiac team must be promptly available and capable of successfully operating on unstable acute ischemic patients in an emergency setting.

15. Cardiac catheterization services should be staffed by a minimum of two physicians licensed by the State of South Carolina who possess the qualifications specified by the governing body of the facility. Protocols should be established that govern initial and continuing granting of clinical staff privileges to physicians to perform diagnostic, therapeutic and/or pediatric catheterizations. In addition, standards should be established to assure that each physician using the service would be involved in adequate numbers of applicable types of cardiac catheterization procedures to maintain proficiency.

16. The Department encourages all applicants and providers to share their outcomes data with appropriate registries and research studies designed to improve the quality of cardiac care.

Quality

No ideal rate has been established for PTCA [PCI] and the rates vary widely by area and population group. The IQI considers PCI to be a potentially over-used procedure and a more average rate equates to better quality care. However, high PCI utilization has not been shown to necessarily be associated with higher rates of inappropriate utilization. Source: http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

There are several national benchmarks for the treatment of heart attacks, such as administration of aspirin and time from door-to-treatment. Whynotthebest.org was established by The Commonwealth Fund to track the performance of hospitals in various measures of health care quality. According to their website, every hospital that performs therapeutic cardiac caths in the state scored at least 96% on their composite ratings for heart attack care in 2010. Source: http://whynotthebest.org

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;

f. Ability of the Applicant to Complete the Project;
g. Financial Feasibility;
h. Staff Resources; and
i. Adverse Effects on Other Facilities.

The Department finds that:

(1) Diagnostic catheterization services are available within forty-five (45) minutes and therapeutic catheterization services within ninety (90) minutes travel time for the majority of South Carolina residents;

(2) Significant cardiac catheterization capacity exists in most areas of the State; and

(3) The preponderance of the literature on the subject indicates that a minimum number of procedures are recommended per year in order to develop and maintain physician and staff competency in performing these procedures.

The benefits of improved accessibility will not outweigh the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CARDIAC CATHETERIZATION PROCEDURES

REGION/FACILITY		# CATH LABS	2008 DIAG	2008 ADULT THERP	2008 TOTAL EQUIV	2008 PED DIAG	2008 PED THERP	2008 PED OTHER	2008 TOTAL EQUIV	2009 DIAG	2009 ADULT THERP	2009 TOTAL EQUIV	2009 PED DIAG	2009 PED THERP	2009 PED OTHER	2009 TOTAL	2010 DIAG	2010 ADULT THERP	2010 TOTAL EQUIV	2010 PED DIAG	2010 PED THERP	2010 PED OTHER	2010 TOTAL
I																							
ANMED HEALTH MEDICAL CENTER	1	4	1,993	1,222	4,437					1,907	1,301	4,509					1,911	1,230	4,371				
GREENVILLE MEMORIAL HOSPITAL		7	3,163	2,467	8,097					2,858	2,302	7,462					2,628	2,061	6,750				
SAINT FRANCIS - DOWNTOWN	2	4	1,906	1,052	4,010					2,077	1,401	4,879					2,275	1,418	5,111				
OCONEE MEMORIAL HOSPITAL		1	882		882					776		776					667		667				
BAPTIST MED CTR-EASLEY	3	1	474		474					400		400					368		368				
MARY BLACK MEMORIAL		1	154		154					150		150					106		106				
SPARTANBURG REGIONAL MEDICAL CTR		4	2,283	1,011	4,305					2,299	964	4,227					2,500	928	4,356				
VILLAGE HOSPITAL	4	1																					
TOTAL REGION I		22	10,855	5,752	22,359					10,467	5,968	22,403					10,455	5,637	21,729				
II																							
CHESTER REGIONAL MEDICAL CENTER		MOBILE	116		116					95		95					110		110				
SELF REGIONAL HEALTHCARE		2	1,324	408	2,140					1,137	396	1,929					1,035	406	1,847				
KERSHAWHEALTH		1	367		367					507		507					461		461				
SPRINGS MEMORIAL HOSPITAL		1	544		544					567		567					489		489				
LEXINGTON MEDICAL CENTER	5	2	1,128	3	1,134					1,242	16	1,274					1,293	54	1,401				
PALMETTO HEALTH BAPTIST		1	275		275					293		293					320		320				
PALMETTO HEALTH RICHLAND		4	3,208	1,170	5,548					3,338	1,245	5,828					3,169	1,134	5,437				
PROVIDENCE HOSPITAL		6	3,460	2,700	8,860					3,474	2,700	8,874					3,332	2,742	8,816				
PIEDMONT MEDICAL CENTER		3	1,595	864	3,323					1,422	759	2,940					1,328	762	2,852				
SOUTH CAROLINA HEART CENTER	6	2	1,829		1,829					1,750		1,750					NO 2010 DATA REPORTED						
TOTAL REGION II		23	13,846	5,145	24,136					13,825	5,116	24,057					11,538	5,099	21,733				
III																							
CAROLINA PINES REGIONAL MEDICAL CTR		1	81		61					62		62					NO 2010 DATA REPORTED						
CAROLINAS HOSPITAL SYSTEM		2	1,155	263	1,681					2,406	547	3,500					1,228	240	1,708				
MCLEOD REGIONAL MEDICAL CENTER		4	1,823	760	3,343					1,504	585	2,694					1,640	619	2,878				
GEORGETOWN MEMORIAL HOSPITAL		1	868	59	986					811	63	737					696	77	850				
CONWAY HOSPITAL		1	557		557					585		585					621		621				
GRAND STRAND REGIONAL MED CTR	7	3	862	580	2,022					1,057	667	2,391					1,238	829	2,896				
LORIS COMMUNITY HOSPITAL		1	238		238					247		247					328		328				
TUOMEY		1	307		307					281		281					204		204				
TOTAL REGION III		14	5,871	1,662	9,195					6,753	1,872	10,497					5,955	1,765	9,485				
IV																							
AIKEN REGIONAL MEDICAL CENTER		1	608	500	1,608					519	243	1,005					448	279	1,006				
BEAUFORT MEMORIAL HOSPITAL		1	386		386					482		482					494		494				
HILTON HEAD HOSPITAL		2	624	235	1,094					478	240	958					454	231	916				
COLLETON MEDICAL CENTER		MOBILE	0		0					0		0					0	0	0				
BON SECOURS ST. FRANCIS XAVIER		1	0		0					0		0					2	0	2				
MUSC MEDICAL CENTER		6	1,435	1,038	3,511	232	217	93	1,208	1,517	1,184	3,885	252	241	130	1,357	1,694	1,227	4,148	266	252	133	1,421
ROPER HOSPITAL		3	1,979	992	3,963					1,943	910	3,763					1,904	982	3,868				
TRIDENT MEDICAL CENTER		2	1,417	392	2,201					1,429	370	2,189					1,321	464	2,249				
REG MED CTR ORANGEBURG-CALHOUN		1	474		474					400		400					271		271				
RALPH HENRY VA MED CTR CHARLESTON		(1)																					
TOTAL REGION IV		18	6,923	3,157	13,237	232	217	93	1,208	6,768	2,947	12,662	252	241	130	1,357	6,588	3,183	12,954	266	252	133	1,421
STATEWIDE TOTALS		77	37,495	15,716	68,927	232	217	93	1,208	37,813	15,903	69,619	252	241	130	1,357	34,536	15,684	65,901	266	252	133	1,421

1 CON ISSUED 5/14/09 FOR A 4TH CATH LAB, SC-09-24.
2 CON ISSUED 7/8/09 FOR A 4TH CATH LAB, SC-09-34; OPERATIONAL 12/30/09.
3 CON ISSUED 6/2/08 TO ALLOW EMERGENT PCI.
4 CON ISSUED 11/22/10 FOR A DIAGNOSTIC LAB, SC-10-34.
5 CON ISSUED 5/12/09 TO ADD 2ND LAB & ALLOW EMERGENT PCI, SC-09-23. CON ISSUED 6/18/10 TO ESTABLISH COMPREHENSIVE CATH SERVICES THROUGH TRANSFER OF AN OPEN HEART SUITE FRDM PROVIDENCE HOSPITAL, SC-10-19.
6 DOCTORS OFFICE; PURCHASED BY PROVIDENCE HOSPITAL.
7 CON ISSUED 3/14/07 FOR A 3RD CATH LAB, SC-07-10.

C. Open Heart Surgery:

1. Definitions:

"Capacity" means the number of open heart surgery procedures that can be accommodated in an open heart surgery unit in one year.

"Open Heart Surgery" refers to an operation performed on the heart or intrathoracic great vessels. It is identified by the following ICD-9-CM procedure codes: 35.10-35.14, 35.20-35.28, 35.31-35.35, 35.39, 35.41-35.42, 35.50-35.51, 35.53-35.54, 35.60- 35.63, 35.70-35.73, 35.81-35.84, 35.91-35.95, 35.98-35.99, 36.03, 36.09, 36.10-36.16, 36.19, 36.2, 36.91, 36.99, 37.10-37.11, 37.32-37.33.

An "Open Heart Surgery Unit" is an operating room or suite of rooms equipped and staffed to perform open heart surgery procedures; such designation does not preclude its use for other related surgeries, such as vascular surgical procedures. A hospital with an open heart surgery program may have one or more open heart surgery units.

"Open Heart Surgical Procedure" means an operation performed on the heart or intrathoracic great vessels within an open heart surgical unit. All activities performed during one clinical session shall be considered one procedure.

"Open Heart Surgical Program" means the combination of staff, equipment, physical space and support services which is used to perform open heart surgery. Adult open heart surgical programs should have the capacity to perform a full range of procedures, including:

1. repair/replacement of heart valves
2. repair of congenital defects
3. cardiac revascularization
4. repair/reconstruction of intrathoracic vessels
5. treatment of cardiac traumas.

In addition, open heart programs must have the ability to implement and apply circulatory assist devices such as intra-aortic balloon and prolonged cardiopulmonary partial bypass.

2. Scope of Services:

A range of non-invasive cardiac and circulatory diagnostic services should be available within the hospital, including the following:

a. services for hematology and coagulation disorders;
b. electrocardiography, including exercise stress testing;
c. diagnostic radiology;
d. clinical pathology services which include blood chemistry and blood gas analysis;

e. nuclear medicine services which include nuclear cardiology;
f. echocardiography;
g. pulmonary function testing;
h. microbiology studies;
i. Coronary Care Units (CCU's);
j. medical telemetry/progressive care; and
k. perfusion.

Backup physician personnel in the following specialties should be available in emergency situations:

a. Cardiology;
b. Anesthesiology;
c. Pathology;
d. Thoracic Surgery; and
e. Radiology.

Each applicant shall document plans for providing cardiac rehabilitation services to its patients or plans for establishing referral agreements with facilities offering cardiac rehabilitation services.

Adult open heart surgery services should be available within 60 minutes one-way automobile travel for 90% of the population. A pediatric cardiac surgical service should provide services for a minimum service area population with 30,000 live births, or roughly 2 million people. Open heart surgery for elective procedures should be available at least 40 hours per week, and elective open heart surgery should be accessible with a waiting time of no more than two weeks. All facilities providing open heart surgery must conform with local, state, and federal regulatory requirements and should meet the full accreditation standards for The Joint Commission (TJC), if the facility is TJC accredited.

Certificate of Need Standards

1. The establishment or addition of an open heart surgery unit requires Certificate of Need review, as this is considered a substantial expansion of a health service.

2. Comprehensive cardiac catheterization laboratories shall only be located in hospitals that provide open heart surgery. The lack of a formal cardiac surgical program within the institution is an absolute contraindication for therapeutic catheterizations due to the risk of arterial damage and subsequent need for emergency bypass surgery.

3. The capacity of an open heart surgery program is 500 open heart procedures per year for the initial open heart surgery unit and each additional dedicated open heart surgery unit (i.e., each operating room equipped and staffed to perform open heart surgery has a maximum capacity of 500 procedures annually).

4. There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit within three years after initiation in any institution in which open heart surgery is performed for adults. In institutions performing pediatric open heart surgery there should be a minimum of 100 pediatric heart operations per open heart surgery unit; at least 75 should be open heart surgery.

5. New open heart surgery services shall be approved only if the following conditions are met:

   A. Each existing unit in the service area (defined as all facilities within 60 minutes one way automobile travel, excluding any facilities located in either North Carolina or Georgia) is performing an annual minimum of 350 open heart surgery procedures per open heart surgery unit for adult services (70 percent of functional capacity). The standard for pediatric open heart cases in pediatric services is 130 procedures per unit. An exception to this requirement may be authorized should an applicant meet both of the following criteria:

      1. There are no open heart surgery programs located in the same county as the applicant; and

      2. The proposed facility currently offers cardiac catheterization services and provided a minimum of 1,200 diagnostic equivalents in the previous year of operation.

   B. An applicant must project that the proposed service will perform a minimum of 200 adult open heart surgery procedures annually per open heart surgery unit within three years after initiation (the standard for pediatric open heart surgery shall be 100 procedures annually per open heart surgery unit within three years after initiation):

      1. The applicant shall provide epidemiological evidence of the incidence and prevalence of conditions for which open heart surgery is appropriate within the proposed service area, to include the number of potential candidates for these procedures;

      2. The applicant shall provide an explanation of how the applicant projects the utilization of the service and the effect of its projected utilization on other open heart surgery services, including:

         a. The number of patients of the applicant hospital who were referred to other open heart surgery services in the preceding three years and the number of these patients who could have been served by the proposed service;

         b. The number of additional patients, if any, who will be generated through changes in referral patterns, recruitment of specific physicians, or other changes in circumstances. The applicant shall

document the services, if any, from which these patients will be drawn; and

c. The existing and projected patient origin information and referral patterns for each open heart surgery service serving patients from the area proposed to be served shall be provided.

6. No new open heart surgery programs shall be approved if the new program will cause the annual caseload of other programs within the proposed service area to drop below 350 adult procedures or 130 pediatric procedures per open heart surgery unit.

7. Expansion of an existing open heart surgery service shall only be approved if the service has operated at a minimum use rate of 70 percent of capacity for each of the past two years and can project a minimum of 200 procedures per year in the new open heart surgery unit. The applicant shall document the other service providers, if any, from which these additional patients will be drawn.

8. The application shall include standards adopted or to be adopted by the service, consistent with current medical practice as published by clinical professional organizations, such as the American College of Cardiology or the American Heart Association, defining high-risk procedures and patients who, because of their conditions, are at high risk and shall state whether high-risk cases are or will be performed or high-risk patients will be served.

9. Open heart surgery services should be staffed by a minimum of two physicians licensed by the State of South Carolina who possess the qualifications specified by the governing body of the facility. Protocols should be established that govern initial and continuing granting of clinical staff privileges to physicians to perform open heart surgery and therapeutic cardiac catheterizations. In addition, standards should be established to assure that each physician using the service will be involved in adequate numbers of applicable types of open heart surgery and therapeutic cardiac catheterizations to maintain proficiency.

10. The open heart surgery service will have the capability for emergency coronary artery surgery, including:

A. Sufficient personnel and facilities available to conduct the coronary artery surgery on an immediate, emergency basis, 24 hours a day, 7 days a week;

B. Location of the cardiac catheterization laboratory(ies) in which therapeutic catheterizations will be performed near the open heart surgery operating rooms; and

C. A predetermined protocol adopted by the cardiac catheterization service governing the provision of PTCA and other therapeutic or high-risk cardiac catheterization procedures or the catheterization of patients at high risk and defining the plans for the patients' emergency care. These high-risk procedures should only be performed with

open heart surgery backup. The cardiac team must be promptly available and capable of successfully operating on unstable acute ischemic patients in an emergency setting.

11. The Department encourages all applicants and providers to share their outcomes data with appropriate registries and research studies designed to improve the quality of cardiac care.

Quality

Volume is a proxy measure for quality. Higher volumes have been associated with better outcomes although some low-volume hospitals have very good outcomes. There is a potential for variation in CABG rates between area populations.

There are several national benchmarks for the treatment of heart attacks, such as administration of aspirin and time from door-to-treatment. Whynotthebest.org was established by The Commonwealth Fund to track the performance of hospitals in various measures of health care quality. According to their website, every hospital that performs open heart surgery in the state scored at least 96% on their composite ratings for heart attack care in 2010. Source: http://whynotthebest.org

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Ability of the Applicant to Complete the Project;
g. Financial Feasibility;
h. Cost Containment;
i. Staff Resources; and
j. Adverse Effects on Other Facilities.

The Department makes the following findings:

1. Open heart surgery services are available within sixty (60) minutes travel time for the majority of residents of South Carolina;

2. Based upon the standards cited above, most of the open heart surgery providers are currently utilizing less than the functional capability (i.e. 70% of maximum capacity) of their existing surgical suites;

3. The preponderance of the literature on the subject indicates that a minimum number of procedures is recommended per year in order to develop and maintain physician and staff competency in performing these procedures; and

4. Increasing geographic access may create lower volumes in existing programs causing a potential reduction in quality and efficiency, exacerbate existing problems regarding the availability of nursing staff and other personnel, and not necessarily reduce waiting time since other factors (such as the referring physician's preference) would still need to be addressed.

5. Research has shown a positive relationship between the volume of open heart surgeries performed annually at a facility and patient outcomes. Thus, the Department establishes minimum standards that must be met by a hospital in order to provide open heart surgery. Specifically, a hospital is required to project a minimum of 200 open heart surgeries annually within three years of initiation of services. This number is considered to be the minimum caseload required to operate a program that maintains the skill and efficiency of hospital staff and reflects an efficient use of an expensive resource. It is in the public's interest that facilities achieve their projected volumes.

6. The State Health Planning Committee recognizes the important correlation between volume and proficiency. The Committee further recognizes that the number of open heart surgery cases is decreasing and that maintaining volume in programs is very important to the provision of quality care to the community.

The benefits of improved accessibility will not outweigh the adverse effects of duplication in evaluating Certificate of Need applications for this service.

REGION/FACILITY	# OPEN HEART UNITS	FY08 ADULTS	FY08 PEDS	FY09 ADULTS	FY09 PEDS	FY10 ADULTS	FY10 PEDS
I							
ANMED HEALTH MEDICAL CENTER	2	226		216		194	
GREENVILLE MEMORIAL MEDICAL CENTER	4	583		596		503	
ST FRANCIS - DOWNTOWN	2	347		392		381	
SPARTANBURG REGIONAL MEDICAL CENTER	2	432		400		450	
TOTAL REGION I	10	1,588		1,604		1,528	
II							
SELF REGIONAL HEALTHCARE	2	116		106		95	
LEXINGTON MEDICAL CENTER *1*	1					0	
PALMETTO HEALTH RICHLAND	2	435		438		384	
PROVIDENCE HOSPITAL *1*	3	784		692		669	
PIEDMONT MEDICAL CENTER	2	164		155		127	
TOTAL REGION II	10	1,499		1,391		1,275	
III							
CAROLINAS HOSPITAL SYSTEM	2	201		177		214	
MCLEOD REGIONAL MEDICAL CENTER	3	429		327		333	
GRAND STRAND REGIONAL MEDICAL CENTER	2	392		361		389	
TOTAL REGION III	7	1,022		865		936	
IV							
AIKEN REGIONAL MEDICAL CENTER	1	65		62		47	
HILTON HEAD HOSPITAL	1	55		67		64	
MUSC MEDICAL CENTER	3	376	215	378	209	361	210
ROPER HOSPITAL	2	409		462		470	
TRIDENT REGIONAL MEDICAL CENTER	1	205		224		189	
VA HOSPITAL (CHARLESTON)	1						
TOTAL REGION IV	9	1,110	215	1,193	209	1,131	210
STATEWIDE TOTALS	35	5,219	215	5,053	209	4,870	210

1 LEXINGTON SERVICE ESTABLISHED THROUGH THE TRANSFER OF AN OPEN HEART SUITE FROM PROVIDENCE 6/18/10, SC-10-19.

CHAPTER IX

MEGAVOLTAGE RADIOTHERAPY & RADIOSURGERY

Cancer is a group of many related diseases, all involving out-of-control growth and spread of abnormal cells. These cells accumulate and form tumors that invade and destroy normal tissue. Cancer is the second leading cause of death, both nationally and in South Carolina, accounting for approximately 22% of all deaths. According to the South Carolina Central Cancer Registry (SCCCR), there were 23,240 new cases of cancer diagnosed in South Carolina in 2010 and 9,180 cancer deaths. Different types of cancer vary in their rates of growth, patterns of spread and responses to different types of treatment. The overall five-year survival rate is approximately 62%. The national death rates decreased 1.8% annually for men and 1.6% for women between 2004 and 2008.

Megavoltage radiation has been utilized for decades as a standard modality for cancer treatment. It is best known as Radiation Therapy, but is also called Radiotherapy, X-Ray Therapy, or Irradiation. It kills cancer cells and shrink tumors by damaging their genetic material, making it impossible for these cells to continue to grow and divide. Approximately 50% of all cancer patients receive radiation therapy at some time during their illness, either alone or in combination with surgery or chemotherapy. It can be used as a therapeutic treatment (to attempt to cure the disease), a prophylactic treatment (to prevent cancer cells from growing in the area receiving the radiation) or as a palliative treatment (to reduce suffering and improve quality of life when a cure is not possible).

Beams of ionizing radiation are aimed to meet at a specific point and delivery radiation to that precise location. The amount of radiation used is measured in "gray" (Gy) and varies depending on the type and stage of cancer being treated. Radiation damages both cancer cells and normal cells, so the goal is to damage as many cancer cells as possible, while limiting harm to nearby healthy tissue. A typical course of treatment lasts for two to 10 weeks, depending on the type of cancer and the treatment goal. The relevant CPT Procedure codes are: 77371-77373, 77402-77404, 77406-77409, 77411-77414, 77416, 77418, 77432, and 0073T.

A. Definitions

There are varying types of radiation treatment and definitions are often used interchangeably. The following definitions apply:

Adaptive Radiation Therapy (ART): Patient setup and/or radiation delivery is evaluated and modified periodically during the treatment course based on imaging and dose measurements made prior to or during treatment.

Conformal Radiation Therapy (CRT): Since the target often has a complex shape, CT, MRI, or PET is used to create a 3-D image of the tumor. Using the image, the computer designs the radiation beams to be shaped exactly (conform) to the contour of the treatment area. Synonyms include Conformal External Beam Radiation Therapy

(CEBRT), 3-D radiation therapy (3-DRT), 3-D Conformal Beam Radiation Therapy (3-DCBRT), 3-D Conformal Radiation Therapy (3-DCRT), and 3-D External Beam Radiation Therapy (3-DEBRT, 3-DXBRT).

Conventional External Beam Radiotherapy (2DXRT) is delivered via 2-D beams using a linear accelerator. Conventional refers to the way the treatment is planned on a simulator to target the tumor. It consists of a single beam of radiation delivered to the patient from several directions. It is reliable, but is being surpassed by Conformal and other more advanced modalities due to the reduced irradiation of healthy tissue.

Because of the increased complexity of treatment planning and delivery techniques, Electronic Portal Imaging Devices (EPIDs) have been developed. The most common EPIDs are video-based systems; on-line digital port images are captured and analyzed before or during treatment. These systems are used for pre-treatment verification of IMRT fields and to reduce errors in patient positioning.

Fractionation: A small fraction of the entire prescribed dose of radiation is given in each treatment or session. Individual treatment plans are created to minimize the side effects for normal tissue. The typical fractionation schedule for adults is once per day, five days a week. Hyperfractionation (Superfractionation) refers to radiation given in smaller doses twice a day. In Hypofractionation, individual doses are given less often than daily, such as in two-five sessions.

Image-Guided Radiation Therapy (IGRT) combines with IMRT or 3DCRT to visualize (by means of EPIDs, kV scans or mV scans) the patient's anatomy during treatments. This allows for confirmation of beam location and adjustment of the beams if needed during treatments due to breathing. IGRT facilitates more accurate patient positioning and reduces healthy tissue damage.

IMRT (Intensity Modulated Radiation Therapy) creates a 3-D radiation dose map to treat the tumor. It uses a multi-leaf collimator to modulate or control the outlines and intensity of the radiation field during cancer treatment. Due to its precision it can spare more healthy tissue, but it also requires detailed data collection and takes longer than conventional therapy.

Stereotactic body radiation therapy (SBRT) is a precision radiation therapy delivery concept derived from cranial stereotactic radiosurgery. It is characterized by one to five fraction delivery of focal high-dose radiation while limiting dose to surrounding normal tissues. SBRT has become an established treatment technique for lung, liver, and spinal lesions.

Stereotactic Radiosurgery (SRS) is a single-session procedure used to treat brain tumors and other brain disorders that cannot be treated by regular surgery. The patient's head is placed in a special frame, which is attached to the patient' skull. The frame is used to aim high-dose radiation beams directly at the tumor inside the patient's head. The radiation dose given in one session is usually less than the total dose that would be given with

radiation therapy. However, the tumor receives a very high one-time dose of radiation with radiosurgery versus smaller fractions over time with radiation therapy. It is also known as Stereotaxic Radiosurgery or Radiation Surgery.

Stereotactic Radiation Therapy (SRT) is an approach similar to Stereotactic Radiosurgery that delivers radiation to the target tissue. However, the total dose of radiation is divided into several smaller doses given over several days, rather than a single large dose. The treatment time per session typically ranges from 30 to 90 minutes for two-five sessions. It can be used to treat both brain and extracranial tumors.

B. Types of Radiation Equipment

1. Particle Beam (Proton)

Particle beams use heavy charged subatomic particles to deliver radiation to the tumor. Unlike the other equipment forms, some particle beams can only penetrate a short distance into tissue. Therefore, they are often used to treat cancers located on the surface of or just below the skin. There are only a few facilities that operate particle beam (or cyclotron) units, which can be used to treat brain cancers and fractionated to treat other cancers. There are currently only 5 facilities in the United States and the cost of more than $100 million will limit their expansion.

2. Linear Accelerator (X-Ray)

The linear accelerator produces high energy x-rays that are collected to form a beam that matches the size and shape of the patient's tumor. The patient lies on a movable couch and radiation is transmitted through the gantry, which rotates around the patient. Radiation can be delivered to the tumor from any angle by rotating the gantry, moving the couch, or moving the accelerator with a robotic arm. The accelerator must be located in a room with lead and concrete walls to keep the rays from escaping. A conventional linac requires modifications, such as additional equipment, in order to be used for IMRT or other advanced techniques.

Minimal equipment requirements for a linear accelerator include:

1. at least 1 teletherapy unit, with an energy exceeding 1 megavolt (MV); the distance from the source to the isocenter must be at least 80 cm;

2. access to an electron beam source or a low energy X-ray unit;

3. adequate equipment to calibrate and measure dosimetric characteristics of all treatment units in the department;

4. capability to provide appropriate dose distribution information for external beam treatment and brachytherapy;

5. equipment for accurate simulation of the treatment units in the department (in general, one simulator can service 2-3 megavoltage treatment units);

6. field-shaping capability; and

7. access to CT scanning capability.

The capacity standards for a linear accelerator vary by the capability of the equipment. A conventional linear accelerator, either with or without EPID, has a capacity of 7,000 treatments per year, based upon an average of 28 patients treated per day, 5 days per week, 50 weeks per year. Linacs with IMRT and IGRT systems (such as Tomotherapy and Novalis TX) take longer to set up and perform treatments than those relying on previously generated images. Therefore, a lower capacity of 5,000 treatments per year is established for such equipment (20 patients treated per day, 5 days per week, 50 weeks per year). IMRT/IGRT machines that perform stereotactic procedures have a lower capacity of 4,500 treatments per year (18 patients treated per day, 5 days per week, 50 weeks per year). MUSC has three linacs designated with a capacity of 5,000 treatments and two with a capacity of 4,500. The Tomotherapy unit at Spartanburg Regional has been designated with a capacity of 4,500 treatments and the Tomotherapy unit at Carolina Regional Radiation Center has been designated as having a capacity of 5,000 treatments per year. Greenville Memorial has a Novalis Brainlab used for stereotactic procedures with a 4,500 treatment capacity. Anderson Memorial replaced an existing linac with one having stereotactic capabilities and a capacity of 4,500 treatments. Lexington Medical Center also has a linac with stereotactic capabilities and a capacity of 4,500 treatments. The capacities for these machines and the need calculations for their service areas have been adjusted accordingly.

There is also linac equipment designed strictly to provide Stereotactic Radiotherapy in 1-5 treatment sessions. These specialized linacs have an even lower capacity because of the treatment time associated with this type of care. The capacity for such equipment is established as 2,000 treatments per year per unit, based on 8 treatments per day, 5 days per week, for 50 days per year. The Cyberknife at Roper Hospital is the only equipment so designated. It is an older generation unit with a previously designated capacity of 1,000 treatments per year. The capacity and need calculations for this facility and service area have also been adjusted.

3. Cobalt-60 (Photon)

This modality, best known by the trade name of Gamma Knife, is used to perform Stereotactic Radiosurgery. It is primarily used to treat brain tumors, although it can also be used for other neurological conditions like Parkinson's Disease and Epilepsy. Its use is generally reserved for cancers that are difficult or dangerous to treat with surgery. The radiation damages the genetic code of the tumor in a single treatment, preventing it from replicating and causing it to slowly shrink. Installation of a Gamma Knife system costs between $3.4 and $5 million, plus an additional $0.25 to $0.5 million every 5-10 years to replenish the cobalt-60 power source.

The Gamma Knife consists of a large shield surrounding a large helmet-shaped device with 201 separate, fixed ports that allow the radiation to enter the patient's head in small beams that converge on the designated target. A rigid frame is attached to the patient's skull to provide a solid reference for both targeting and treatment. The patient is then sent for imaging, to accurately determine the position of the target. The computer system develops a treatment plan to position the patient and the paths and doses of radiation. The patient is positioned with the head affixed to the couch, and the treatment is delivered. The patient goes home the same day.

C. Status of South Carolina Providers

1. Linear Accelerators

There are currently 31 facilities either operating or approved for a total of 57 linear accelerators in South Carolina. In 2010, the 49 operational linear accelerators performed 269,016 treatments, or an average of 5,490 treatments per unit.

2. Gamma Knife

Palmetto Health Richland performed 218 Gamma Knife treatments in 2010. MUSC's Gamma Knife became operational in February 2010 and performed 47 treatments that year.

D. Certificate of Need Standards for Radiotherapy

1. The capacity of a conventional linear accelerator, either with or without EPID, is 7,000 treatments per year.

2. Linear accelerators providing IMRT or IGRT have a capacity of 5,000 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.

3. IMRT/IGRT linear accelerators performing stereotactic procedures have a capacity of 4,500 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.

4. Linear Accelerators designed strictly to provide Stereotactic Radiotherapy have a capacity of 2,000 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.

5. There are 13 service areas established for Radiotherapy units as shown on the following chart.

6. New Radiotherapy services shall only be approved if the following conditions are met:

   A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant's CON application; and

   B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold. If the new equipment is a specialized radiotherapy unit as described in Standards 2, 3 or 4 above, then the applicant may propose an annual capacity based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant. The applicant must document where the potential patients for this new service will come from and where they are currently being served, to include the expected shift in patient volume from existing providers.

7. Expansion of an existing service, whether the expansion occurs at the existing site or at an alternate location in the service area, shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum use rate of 50 percent of capacity per year on the additional equipment within three years of its implementation. If the additional equipment is a specialized radiotherapy unit as described in either Standards 2, 3 or 4 above, then the existing provider may propose an annual capacity for that additional equipment, based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant.

8. The applicant shall project the utilization of the service and document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service.

9. The applicant must affirm the following:

   A. All treatments provided will be under the control of a board certified or board eligible radiation oncologist;

   B. The applicant will have access to a radiation physicist certified or eligible for certification by the American Board of Radiology or its equivalent;

C. The applicant will have access to simulation equipment capable of precisely producing the geometric relationships of the equipment to be used for treatment of the patient;

D. The applicant will have access to a custom block design and cutting system; and

The institution shall operate its own tumor registry or actively participate in a central tumor registry.

Quality

Incorrect doses of radiation can be dangerous. Two patients in New York died from lethal overdoses. In response, the Medical Imaging & Technology Alliance and the Advanced Medical Technology Alliance recently announced the Radiation Therapy Readiness Check Initiative, which is intended to incorporate safety-check mechanisms into radiation therapy equipment. The manufacturers have agreed to make equipment modifications to improve patient safety, by preventing equipment from operating unless the users verify that safeguards are in place.

The initiative requires medical physicists to record the performance of quality-assurance reviews of treatment plans. Technicians are required to perform beam modification checks, verify correct placement of machine accessories, and confirm correct patient placement. Individual manufacturers will be responsible for incorporating the safety-check software into new equipment and creating software add-ons that can be incorporated into existing equipment. However, some older machines may not be capable of adding the safeguards.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for these services:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Financial Feasibility; and
g. Cost Containment.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

RADIOTHERAPY

SERVICE AREAS	2010 POPULATION	# OF LIN ACC	POP PER LIN ACC	TOTAL AREA TREATMENTS	TREATMENTS PER LIN ACC	PLANNING AREA CAPACITY	PERCENT CAPACITY
ANDERSON,OCONEE	261,399	3	87,133	17,325	5,775	18,500	93.6%
GREENVILLE,PICKENS	570,449	6	95,075	34,189	5,698	39,500	86.6%
CHEROKEE,SPARTANBURG UNION	368,610	5	73,722	19,525	3,905	32,500	60.1%
CHESTER,LANCASTER,YORK	335,865	3	111,955	13,358	4,453	21,000	63.6%
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	218,708	2	109,354	7,688	3,844	14,000	54.9%
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	770,056	9	85,562	46,242	5,138	60,500	76.4%
CHESTERFIELD, DARLINGTON DILLON, FLORENCE, MARION MARLBORO	346,357	5	69,271	23,002	4,600	32,500	70.8%
CLARENDON,LEE,SUMTER	161,647	2	80,824	9,846	4,923	14,000	70.3%
GEORGETOWN,HORRY WILLIAMSBURG	363,872	5	72,774	26,461	5,292	33,000	80.2%
BAMBERG,CALHOUN ORANGEBURG	123,663	2	61,832	6,318	3,159	14,000	45.1%
ALLENDALE,BEAUFORT, HAMPTON,JASPER	218,519	2	109,260	9,918	4,959	14,000	70.8%
BERKELEY,CHARLESTON COLLETON,DORCHESTER	703,499	11	63,954	46,264	4,206	60,000	77.1%
AIKEN,BARNWELL	182,720	2	91,360	8,880	4,440	14,000	63.4%
STATE TOTAL	4,625,364	57	81,147	269,016	4,720	367,500	73.2%

MEGAVOLTAGE VISITS

REGION & FACILITY	COUNTY	# UNITS	FY 2008	FY 2009	FY 2010
REGION I					
ANMED HEALTH MEDICAL CENTER *1*	ANDERSON	2	12,781	12,449	11,923
GIBBS REGIONAL CANCER CTR SATELLITE *2*	CHEROKEE	1	---	---	---
CANCER CENTERS OF THE CAROLINAS	GREENVILLE	1	5,821	4,834	5,325
CANCER CENTERS CAROLINAS - EASTSIDE		1	10,553	9,487	7,678
GREENVILLE MEMORIAL MEDICAL CENTER		3	18,309	15,433	16,846
GREER MEDICAL CAMPUS CANCER CTR *3*		1	---	---	4,340
CANCER CTRS CAROLINAS - OCONEE CO.	OCONEE	1	6,550	6,279	5,402
CANCER CTRS CAROLINAS - MARY BLACK *4*	SPARTANBURG	1	---	---	---
SPARTANBURG REGIONAL MED CTR		2	17,480	18,512	19,525
VILLAGE AT PELHAM CANCER CENTER *5*		1	---	---	---
REGION II					
SELF REGIONAL HEALTHCARE	GREENWOOD	2	6,589	6,747	7,688
LANCASTER RADIATION THERAPY CTR *6*	LANCASTER	1	---	---	---
LEXINGTON MEDICAL CENTER	LEXINGTON	2	9,599	10,433	10,431
NEWBERRY ONCOLOGY ASSOCIATES *7*	NEWBERRY	1	---	---	2,565
PALMETTO HEALTH RICHLAND	RICHLAND				
LINEAR ACCELERATORS		2	11,710	14,107	11,783
GAMMA KNIFE		1	206	210	218
SOUTH CAROLINA ONCOLOGY ASSOCIATES		4	26,881	22,671	21,463
ROCK HILL RADIATION THERAPY CENTER	YORK	2	14,210	13,416	13,358
REGION III					
CAROLINAS HOSPITAL SYSTEM	FLORENCE	1	4,557	5,015	3,650
MCLEOD REGIONAL MEDICAL CENTER *8*		4	19,164	17,176	19,352
FRANCIS B FORD CANCER CENTER *9*	GEORGETOWN	1	5,903	5,305	5,515
CAROLINA REGIONAL CANCER CENTER	HORRY	2	14,335	15,613	20,946
CAROLINA REG CA CTR - CONWAY *10*		1			
CAROLINA REG CA CTR - MURRELS INLET *11*		1			
TUOMEY	SUMTER	2	9,407	10,812	9,846
REGION IV					
RADIATION ONCOLOGY CTR OF AIKEN *12*	AIKEN	2	7,371	7,886	8,880
SJC ONCOLOGY SERVICES - SC	BEAUFORT	1	6,369	6,182	5,481
BEAUFORT MEMORIAL HOSPITAL		1	4,881	4,633	4,437
MUSC MEDICAL CENTER *13*	CHARLESTON				
LINEAR ACCELERATORS		5	16,806	18,184	18,707
GAMMA KNIFE		1			47
ROPER WEST ASHLEY CANCER CTR *14*		4	13,403	14,440	14,250
TRIDENT MEDICAL CENTER *15*		2	11,461	11,664	13,307
REG MED CTR ORANGEBURG/CALHOUN *16*	ORANGEBURG	2	7,060	6,545	6,318

	TOTAL	**57**	**261,200**	**257,823**	**269,016**

1 CON ISSUED 1/30/12 TO REPLACE ONE OF OF THE EXISTING LINACS WITH ONE WITH STEREOTACTIC RADIOSURGERY CAPABILITIES, SC-12-03.
2 LINAC APPROVED 3/31/03; APPEALED. CON ISSUED BY SUPREME COURT RULING 3/31/10.
3 CON ISSUED 10/12/07, SC-07-53.
4 CON ISSUED BY SUPREME COURT RULING 3/31/10.
5 CON TO MOVE A LINAC FROM SRMC TO VILLAGE AT PELHAM APPEALED 2/12/08. APPEAL WITHDRAWN, CON ISSUED 7/25/11, SC-11-25.
6 CON APPROVED 2/15/08; APPEALED. APPEAL DISMISSED 8/5/09; SC-09-39 ISSUED 8/12/09.
7 CON APPROVED 3/20/06.
8 CON ISSUED 8/22/11 TO REPLACE ONE OF OF THE EXISTING LINACS WITH ONE WITH STEREOTACTIC RADIOSURGERY CAPABILITIES, SC-11-30.
9 CON APPROVED 9/26/11TO RELOCATE THE FACILTY FROM GEORGETOWN TO MURRELL'S INLET; APPEALED.
10 CON APPROVED 12/28/11 TO INSTALL A LINAC; APPEALED.
11 CON APPROVED 9/26/11 TO RELOCATE ONE LINAC FROM THE EXISTING LOCATION IN MYRTLE BEACH TO MURRELL'S INLET; APPEALED.
12 CON ISSUED TO TRANSFER OWNERSHIP FROM AIKEN REGIONAL & ADD 2ND LINAC 6/11/09, SC-09-29.
13 CON FOR GAMMA KNIFE ISSUED 6/8/09. CON FOR 5TH LINAC ISSUED 7/8/09.
14 CON APPROVED FOR 3RD CONVENTIONAL LINAC 8/5/09.
15 CON ISSUED FOR REPLACEMENT LINAC 2/26/09 SC-09-07.
16 CON ISSUED FOR 2ND LINAC 9/28/10, SC-10-31.

Certificate of Need Standards for Stereotactic Radiosurgery

1. The capacity of a dedicated Stereotactic Radiosurgery unit is 300 procedures annually. This is based on an average of two procedures per day times three days per week times 50 weeks per year.

2. The service area for a dedicated Stereotactic Radiosurgery unit is defined as all facilities within 90 minutes one-way automobile travel time.

3. New Radiosurgery services shall only be approved if the following conditions are met:

   A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the most recent year; and

   B. An applicant must project that the proposed service will perform a minimum of 200 procedures annually within three years of initiation of service, without reducing the utilization of existing units below the 80 percent threshold.

4. Expansion of an existing radiosurgery service shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum of 200 procedures per year on the additional equipment within three years of its implementation.

5. The applicant shall project the utilization of the service, to include:

   A. Epidemiological evidence of the incidence and prevalence of conditions for which radiosurgery treatment is appropriate, to include the number of potential patients for these procedures;

   B. The number of patients of the applicant who were referred to other radiosurgery providers in the preceding three years and the number of those patients who could have been served by the proposed service; and

   C. Current and projected patient origin information and referral patterns for the facility's existing radiation therapy services. The applicant shall document the number of additional patients, if any, that will be generated through changes in referral patterns, recruitment of specific physicians or other changes in circumstances.

6. The applicant must include letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service.

7. The applicant must document that protocols will be established to assure that all clinical radiosurgery procedures performed are medically necessary and that alternative treatment modalities have been considered.

8. The applicant must affirm the following:

   A. The radiosurgery unit will have a board certified neurosurgeon and a board certified radiation oncologist, both of whom are trained in stereotactic radiosurgery;

   B. The applicant will have access to a radiation physicist certified or eligible for certification by the American Board of Radiology or its equivalent;

   C. Dosimetry and calibration equipment and a computer with the appropriate software for performing radiosurgical procedures will be available;

   D. The applicant has access to a full range of diagnostic technology, including CT, MRI and angiography; and

   E. The institution shall operate its own tumor registry or actively participate in a central tumor registry.

9. Due to the unique nature and limited need for this type of equipment, the applicant should document how it intends to provide accessibility for graduate medical education students in such fields as neurosurgery and oncology.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for these services:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Financial Feasibility; and
g. Cost Containment.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CHAPTER X

POSITRON EMISSION TECHNOLOGY

A. POSITRON EMISSION TOMOGRAPHY (PET) AND PET/CT

Positron Emission Tomography (PET) uses small concentrations of radioactive material injected into the blood to capture color images of cellular metabolism. The tracer nucleotide most frequent used is FDG (Fluorodeoxyglucose). PET allows the study of metabolic processes such as oxygen consumption and utilization of glucose and fatty acids. Cancer cells utilize more glucose than normal cells, so PET can be used to reveal the presence or track the spread of cancer. It is quantitative and very sensitive, so only small amounts of isotopes are needed. The isotopes only have about a two-hour half-life and are quickly expelled from the body.

PET was developed in the 1970s and was primarily used for research focusing on cerebral function and detection and assessment of coronary artery disease. Recent research has centered on the diagnosis and staging of cancer and neurological applications such as epilepsy, Alzheimer's and Parkinson's diseases. PET is covered for Medicare patients with lung, breast, colorectal, head and neck and esophageal cancers; melanomas; certain thyroid diseases; neurology; and heart disease uses.

The process takes approximately 45 minutes to an hour to perform. A Computerized Tomography (CT) scanner produces cross-sectional images of anatomical details of the body. These images are taken separately, and then fused with the PET images for interpretation. The process requires a nuclear medical technologist certified for both PET and CT or dually certified in radiography.

Several manufacturers have now developed combined PET/CT scanners that can acquire both image sets simultaneously, giving radiologists a more complete picture in about half the time. A PET/CT scanner costs between $2,000,000-$2,7000,000 dollars. Installing and operating a PET scanner typically costs around $1,600,000 in capital costs plus annual staffing and operational costs of $800,000. Charges vary from around $2,500 - $4,000 depending on the type and location of the scan.

Due to the on-going development of this technology, it is anticipated that PET and PET/CT will become a standard diagnostic modality in the fields of cardiology, oncology and neurology. Due to the current cost of this technology and the uses approved for reimbursement, it is more appropriate that this technology be available for health care facilities providing specialized therapeutic services such as open heart surgery and radiation oncology. Note: in the Certificate of Need standards cited below, the terms PET and PET/CT are interchanged. The Department does not differentiate between these modalities in defining these standards. The addition of a CT component to an existing PET service is not considered to be a new service that would trigger CON review and is interpreted by the Department to be the replacement of like equipment with similar capabilities.

The operational or approved PET scanners in the state are listed on the following pages.

Certificate of Need Standards

(1) Hospitals that provide specialized therapeutic services (open heart surgery and/or radiation therapy) should have either fixed or mobile PET services for the diagnosis of both inpatients and outpatients. Other hospitals must document that they provide a sufficient range of comprehensive medical services that would justify the need for PET services. Applicants for a freestanding PET service not operated by a hospital must document referral agreements from health care providers that would justify the establishment of such services.

(2) Full-time PET scanner service is defined as having PET scanner services available five days per week. Fixed PET scanners are considered to be in operation five days per week. Capacity is considered to be 1,500 procedures annually. For PET/CT equipment, only procedures that utilize the PET component should be counted; procedures using the CT component as a stand-alone scanner are not included. Capacity for shared mobile services will be calculated based on the number of days of operation per week at each participating facility.

(3) Applicants proposing new fixed PET services must project at a minimum 750 PET clinical procedures per year (three clinical procedures/day x 250 working days) by the end of the third full year of service. The projection of need must include proposed utilization by both patient category and number of patients to be examined, and must consider demographic patterns, patient origin, market share information, and physician/patient referrals. An existing PET service provider must be performing at 1,250 clinical procedures (five clinical procedures x 250 days) per PET unit annually prior to the approval of an additional PET machine.

(4) In order to promote cost-effectiveness, the use of shared mobile PET units should be considered. Applicants for a shared mobile scanner must project an annual minimum of three clinical procedures/day times the number of days/week the scanner is operational at the facility by the end of the third full year of service.

(5) The applicant must demonstrate through cooperative and sharing agreements and letters of support how it will accommodate physicians, other health care institutions and patients from its own region and beyond.

(6) The applicant agrees in writing to provide to the Department utilization data on the operation of the PET service.

(7) The Department encourages all applicants and providers to share their outcome data with appropriate registries and research studies designed to improve the quality of patient care.

(8) CMS requires that a provider seeking Medicare reimbursement must be accredited after January 1, 2012.

POSITRON EMISSION TOMOGRAPHY (PET) AND PET-CT UTILIZATION

REGION/COUNTY	FACILITY	SCANNERS	FY08 SCANS	FY09 SCANS	FY10 SCANS	CON/DATE
I						
ANDERSON	ANMED HEALTH CANCER CENTER	MOBILE 2 DAYS	509	502	565	
GREENVILLE	THE CAROLINAS CLINICAL PET INSTITUTE	FIXED	2,330	2,413	2,269	
GREENVILLE	GREENVILLE MEMORIAL HOSPITAL	MOBILE 4 DAYS	661	908	891	
GREENVILLE	ST. FRANCIS - EASTSIDE	MOBILE 2 DAYS				CON 10/19/11
SPARTANBURG	SPARTANBURG REGIONAL MEDICAL CTR	FIXED	1,589	1,749	1,643	
II						
GREENWOOD	SELF REGIONAL HEALTHCARE	MOBILE 3 DAYS	545	746	656	
LEXINGTON	LEXINGTON MED CTR - LEXINGTON	MOBILE 3 DAYS	444	428	474	
RICHLAND	PALMETTO HEALTH BAPTIST	FIXED	954	946	922	
RICHLAND	SOUTH CAROLINA HEART CENTER	FIXED	---	549	934	CON 3/17/08
RICHLAND	SOUTH CAROLINA ONCOLOGY ASSOC	FIXED	2,213	2,256	2,297	
YORK	PIEDMONT MEDICAL CENTER	MOBILE 2 DAYS	1,085	1,117	1,254	
III						
FLORENCE	CAROLINAS HOSPITAL SYSTEM	MOBILE 1 DAY	248	230	258	
FLORENCE	MCLEOD REGIONAL MEDICAL CENTER	FIXED	672	667	736	
GEORGETOWN	GEORGETOWN MEMORIAL HOSPITAL	MOBILE 1 DAY PER 2 WEEKS	237	211	191	CON 10/10/08 TO SHARE 1 DAY / 2 WEEKS
GEORGETOWN	WACCAMAW COMMUNITY HOSPITAL	MOBILE 1 DAY PER 2 WEEKS	7	164	224	CON 10/10/08 TO SHARE 1 DAY / 2 WEEKS
HORRY	ASSOCIATED MEDICAL SPECIALISTS	FIXED	---	---	---	CON ISSUED 5/13/11
HORRY	COASTAL CANCER CENTER	FIXED	650	1,306	1,404	
HORRY	GRAND STRAND REGIONAL MEDICAL CTR	MOBILE 2 DAYS	776	636	533	
HORRY	CONWAY HOSPITAL	MOBILE 2 DAYS	199	128	95	
SUMTER	TUOMEY	MOBILE 1/2 DAY	191	227	251	
IV						
AIKEN	AIKEN REGIONAL MEDICAL CENTER	MOBILE 1 DAY	341	347	302	
BEAUFORT	BEAUFORT IMAGING CENTER	MOBILE 2 DAYS	226	266	313	
BEAUFORT	SOUTH CAROLINA CANCER SPECIALISTS	FIXED	---	293	202	
CHARLESTON	MUSC MEDICAL CENTER	FIXED	1,559	1,966	1,994	
CHARLESTON	ROPER WEST ASHLEY CANCER CENTER	FIXED	1,390	1,423	1,346	RELOCATED 8/21/09
CHARLESTON	CHARLESTON RADIOLOGISTS	MOBILE 1 DAY	467	408	527	
CHARLESTON	TRIDENT HOSPITAL	FIXED	---	---	---	CON 2/28/11
JASPER	CANDLER	FIXED	---	293	202	OWNERSHIP CHANGED 10/7/11, FORMERLY SCCS
ORANGEBURG	REGIONAL MEDICAL CENTER OF ORANGEBURG & CALHOUN COUNTIES	MOBILE 2 DAYS	66	75	116	CONVERTED TO PET/CT 6/17/09
		TOTALS	17,359	20,254	20,599	

B. POSITRON EMISSION MAMMOGRAPHY (PEM)

Positron Emission Mammography (PEM) is a form of PET that uses high-resolution detection technology for imaging the breast. It creates images that are more easily compared to mammography since they are acquired in the same position. As with PET, a radiotracer is administered and the camera is used to provide a higher resolution image. However, the administered dose of FDG is only about half the amount of whole-body PET, which reduces the radiation dose to the patient.

PEM imaging is used for pre-surgical planning and staging, monitoring response to therapy, and monitoring for recurrence of breast cancer. It detects lesions as small as 1.6 mm, which is not possible with whole-body PET. Three-dimensional reconstruction of the PEM images is also possible. PEM drastically reduces the number of false positives resulting in unnecessary biopsies incurred by patients using conventional mammography.

The actual scan takes 4-10 minutes and the entire process takes approximately 40 minutes to perform. The process requires a nuclear medical technologist certified to inject radiopharmaceuticals for handling of FDG, and either a mammography or nuclear medicine technologist to perform patient positioning and biopsy. The exams can be read either by a breast imaging radiologist or a nuclear medicine physician.

PEM was cleared for marketing by the U.S. Food and Drug Administration (FDA) in August 2003, and there are now more than 50 scanners installed worldwide. The equipment costs between $500,000 and $725,000.

Certificate of Need Standards

(1) PEM scanners are considered to be in operation five days per week but because of their limited focus no capacity standard is established.

(2) Hospitals that provide comprehensive cancer treatment services (including radiation therapy) are appropriate locations for fixed or mobile PEM services for the detection of breast cancer. Other hospitals must document that they treat a sufficient number of breast cancer patients that would justify the need for PEM services.

(3) The applicant must demonstrate through cooperative and sharing agreements and letters of support how it will accommodate physicians, other health care institutions and patients from its own region and beyond.

(4) The applicant agrees in writing to provide to the Department utilization data on the operation of the PEM service.

(5) The Department encourages all applicants and providers to share their outcome data with appropriate registries and research studies designed to improve the quality of patient care.

(6) CMS requires that a provider seeking Medicare reimbursement must be accredited after January 1, 2012.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Ability of the Applicant to Complete the Project; and
g. Cost Containment.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CHAPTER XI

OUTPATIENT FACILITIES

Outpatient facility means a facility providing community service for the diagnosis and treatment of ambulatory patients: (1) that is operated in connection with a hospital; or (2) in which patient care is under the professional supervision of a licensed physician; or (3) that offers to patients not requiring hospitalization the services of licensed physicians and makes available a range of diagnostic and treatment services. Hospital-based outpatient departments vary in scope, but generally include diagnostic laboratory, radiology, and clinical referral services.

A. Ambulatory Surgical Facility

Ambulatory surgery, often described as outpatient or same-day surgery, may be provided in either a hospital or a freestanding Ambulatory Surgical Facility (ASF). An ASF is a distinct, freestanding, self-contained entity that is organized, administered, equipped and operated exclusively for the purpose of performing surgical procedures or related care, treatment, procedures, and/or services, for which patients are scheduled to arrive, receive surgery, or related care, treatment, procedures, and/or services, and be discharged on the same day. The owner or operator makes the facility available to other providers who comprise an organized professional staff, i.e. an open medical staff. This definition does not apply to any facility used as an office or clinic for the private practice of licensed health care professionals.

For purposes of this Plan, an endoscope is defined as a flexible, semi-flexible or rigid instrument, which may or may not have a light attached, that is inserted into a natural orifice in a non-sterile, clean environment, to visually inspect for purposes of screening and diagnosis and to perform therapeutic treatment of the interior of a bodily canal or a hollow organ (such as the colon, bladder, stomach or nasal sinuses).

An Endoscopy ASF is defined as one organized, equipped, and operated exclusively for the purpose of performing surgical procedures or related treatments through the use of an endoscope. Any appropriately licensed and credentialed medical specialist can perform endoscopy only surgical procedures or related treatments at an Endoscopy ASF.

A substantial increase has occurred in both the number and percentage of ambulatory surgeries performed and in the number of approved ASFs. This trend has generally been encouraged because many surgical procedures can be safely performed on an outpatient basis at a lower cost. However, hospitals have expressed concern that ASFs that are not hospital joint ventures are impacting their ability to fund their services. From 2003-2008, an average of 331 ASFs opened nationally each year while 59 closed or merged with other facilities per year. CMS is considering replacing volume-based reimbursement with a value-based purchasing system. This could potentially reward higher-quality providers and would have the greatest impact on gastrointestinal, eye, nervous system, and musculoskeletal surgeries (90% of total 2009 ASF procedures).

In 2010, a total of 340,346 outpatient surgeries and 214,755 endoscopies were performed in either a freestanding surgical center or a hospital in South Carolina, accounting for 68.7% of all surgeries and 87.7% of all endoscopies.

Certificate of Need Standards

1. The county in which the proposed facility is to be located is considered to be the service area for inventory purposes. The applicant may define a proposed service area that encompasses additional counties, but the largest percentage of the patients to be served must originate from the county in which the facility is to be constructed.

2. The applicant must identify the physicians who are affiliated or have an ownership interest in the proposed facility by medical specialty. These physicians must identify where they currently perform their surgeries and whether they anticipate making any changes in staff privileges or coverage should the application be approved.

3. For a new facility, the applicant must document where the potential patients for the facility will come from and where they are currently being served, to include the expected shift in patient volume from existing providers. For the expansion of an existing facility, the applicant must provide patient origin information on the current facility.

4. The applicant must document the need for the expansion of or the addition of an ASF, based on the most current utilization data available. This need documentation must include the projected number of surgeries or endoscopic procedures to be performed by medical specialty. The existing resources must be considered and documentation presented as to why the existing resources are not adequate to meet the needs of the community.

5. It is recommended that an application for a new ASF should contain letters of support from physicians in the proposed service area other than those affiliated with the proposed facility.

6. The applicant must document the potential impact that the proposed new ASF or expansion of an existing ASF will have upon the existing service providers and referral patterns.

7. All new Certificate of Need approvals by the Department will not restrict the specialties of ASFs. However, the Department believes that Ambulatory Surgery Facilities open to and equipped for all surgical specialties will better serve the community than those targeted towards a single specialty or group of

practitioners. For an ASF approved to perform only endoscopic procedures, another CON would be required before the center could provide other surgical specialties.

8. All proposed Ambulatory Surgical Facilities, other than those restricted to endoscopic procedures only, must have a minimum of two operating rooms.

9. Before an application for a new general Ambulatory Surgery Facility can be accepted for filing in a county having a current population of less than 100,000 people, all general ASFs in the county must have been licensed by the Department and operational for an entire year and must have submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The requirements that all ASFs must have been licensed and operational for an entire year and submitted utilization data to the Department will not be applied to applicants for a ASF filing in a county having a current population of greater than 100,000 people.

10. Endoscopy suites are considered separately from other operating rooms. Therefore, endoscopy-only ASF's do not impact other ASF's and are not considered competing applicants for CON review purposes. Before an application for a new endoscopy-only ASF can be accepted for filing in a county having a current population of less than 100,000 people, all ASFs with endoscopy suites in the county must have been licensed by the Department and operational for an entire year and must have submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The requirements that all ASFs with endoscopy suites must have been licensed and operational for an entire year and submitted utilization data to the Department will not be applied to applicants for a new endoscopy-only ASF filing in a county having a current population of greater than 100,000 people.

11. The approval of a new general or endoscopy-only ASF in a county does not preclude an existing facility from applying to expand its number of operating rooms and/or endoscopy suites. The merger of two existing ASFs in a county to construct a consolidated ASF does not constitute a "new ASF" for the purpose of interpreting Standard 9.

12. The applicant for a new ambulatory surgery facility must provide a written commitment that the facility will accept Medicare and Medicaid patients, and that un-reimbursed services for indigent and charity patients will be provided at a percentage that is comparable to all other existing ambulatory surgery facilities, if any, in the service area.

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Facilities providing ambulatory surgery services must conform to local, state, and federal regulatory requirements and must commit to seek accreditation from CMS or any accrediting body with deemed status. Ambulatory surgical services are generally available within 30 minutes one-way automobile travel time of most South Carolina

residents. Most ASFs operate five days a week, with elective surgery being scheduled several days in advance.

Quality

The ASC Quality Collaboration (ASCQC) is a voluntary cooperative effort between a number of organizations and companies working to ensure that quality data are measured and reported in a meaningful way. Participants in the National Quality Forum (NQF) include CMS, TJC, AAAJC, American College of Surgeons (ACOS), American Osteopathic Association (AOA), Association of periOPerative Registered Nurses (AORN), and Hospital Corporation of American (HCA).

The NQF has identified 6 standardized measurements that are feasible and useable as quality indicators. These are:

1. Patient burn;
2. Prophylactic IV antibiotic timing;
3. Patient falls within facility;
4. Wrong site, side, patient, procedure, or implant;
5. Hospital transfer/admission; and
6. Appropriate surgical site hair removal.

These quality indicators are proposed as goals for performance improvement measurement and improvement. CMS is developing a quality measure reporting system for ASFs, but the guidelines have not been released yet. Facilities will eventually face a two percent financial penalty for failing to report data, but, for now, any data collection efforts are voluntary.

If and when a data reporting system is created under CMS, the results for ASFs should be used in evaluating CON applications.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Adverse Effects on Other Facilities
c. Community Need Documentation;
d. Distribution (Accessibility);
e. Financial Feasibility;
f. Cost Containment;
g. Projected Revenues;
h. Projected Expenses;
i. Ability of the Applicant to Complete the Project; and
j. Staff Resources.

The number of surgeries performed on an outpatient basis and the number of ASFs approved and licensed have increased over time. However, there is concern that ASFs are being proposed as a method of increasing reimbursement for procedures currently being performed in physicians' offices through the "facility fee" built into the reimbursement mechanisms, to the detriment of a hospital's ability to provide the range of services needed. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

2010 ASF Utilization

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Region I:										
AnMed Health Medicus Surgery Center	Anderson	3		3	4,629	743	5,372	1,543		
Bearwood Ambulatory Surgery Center	Anderson	1		1	404		404	404		
Physician Surgery Center at AnMed Health	Anderson	3		3	2123		2,123	1,062		
Upstate Endoscopy Center	Anderson		2	2		5,739	5,739			
Center for Special Surgery, The	Greenville	2		2	1,634		1,634	817		
Cross Creek Surgery Center	Greenville	4		4	2,817		2,817	704		
Endoscopy Center of the Upstate	Greenville		3	3		4,900	4,900		1,633	
Greenville Endoscopy Center	Greenville		3	3		6,027	6,027		2,009	
Greenville Endoscopy Center - Patewood	Greenville		3	3		6,266	6,266		2,089	
GHS Outpatent Surgery Center – Patewood	Greenville	6	2	8	6,458	2,397	8,855	1,076	1,199	
Greenville Surgery Center	Greenville	4		4	3,451		3,451	863		
Jervey Eye Center	Greenville	3		3	3,474	1	3,475	1,158		
Upstate Surgery Center	Greenville	2		2	2,874		2,874	1,437		
Blue Ridge Surgery Center	Oconee	2		2	1,940		1,940	970		
Synergy Spine Center	Oconee	2		2	546		546	273		*1*
Ambulatory Surgery Ctr - Spartanburg	Spartanburg	7	2	9	7,534	3,195	10,729	1,076	1,598	
Spartanburg Surgery Center	Spartanburg	4		4	4,074		4,074	1,019		*2*

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Surgery Center at Pelham	Spartanburg	4	2	6	3,471	1,437	4,908	868	719	
Westside Eye Center	Spartanburg	2		2	1,429					
Region II:										
Greenwood Endoscopy Center	Greenwood		4	4		9,094			2,274	
Surgery Ctr. at Self Memorial Hospital	Greenwood	5		5	4,560	81	4,641	912		
Surgery Center at Edgewater	Lancaster	3	2	5	2,244	48	2,292	748	24	
Surgery & Laser Center at Professional Park	Laurens	2		2	2,857		2,857	1,429		
(Columbia Surgery Center)	Lexington	(0)		(0)						3
Midlands Endoscopy Center	Lexington		2	2		2,337			1,169	
Moore Orthopaedic Clinic Outpatient Surgery	Lexington	4		4	3,882		3,882	1,941		4
Outpt Surgery Center Lexington Med Ctr - Irmo	Lexington	4		4	1,574		1,574	394		
Outpt Surgery Center Lexington Med Ctr - Lexington	Lexington	4	1	5	1,919	1,467	3,386	480	1,467	
South Carolina Endoscopy Center	Lexington		4	4		9,749	9,749		2,437	
Urology Surgery Center	Lexington	2		2	1,915		1,915	958		
Berkeley Endoscopy Center	Richland		2	2		2,443	2,443		1,222	
Columbia Eye Surgery Center	Richland	4		4	5,390		5,390	1,348		
Columbia GI Endoscopy Center	Richland		4	4		6,178	6,178		1,545	
Lake Murray Endoscopy Center	Richland		2	2		1,642	1,642		821	
Midlands Orthopaedics Surgery Center	Richland	3		3	3,046		3,046	1,015		

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Palmetto Endoscopy Suite	Richland		2	2						*5*
Palmetto Surgery Center	Richland	4		4	5,278		5,278	1,320		
Parkridge Surgery Center	Richland	4		4	3,035		3,035	759		
South Carolina Endoscopy Center - North East	Richland		5	5		3,806	3,806		761	
South Carolina Med Endoscopy Ctr.	Richland		2	2		2,850	2,850		1,425	*6*
Carolina Surgical Center	York	4		4	5,531		5,531	1,383		
Center for Orthopaedic Surgery	York	3		3	3,650		3,650			
York County Endoscopy Center	York		3	3		5,730				*7*
Region III:										
Darlington Endoscopy Center	Darlington		2	2		642	642		321	
Florence Surgery & Laser Center	Florence	2		2	2,302		2,302	1,151		
McLeod Ambulatory Surgery Center	Florence	2		2	1,557		1,557	779		
Physicians Surgical Center of Florence	Florence	4	2	6	2,340	2,424	4,764	585	1,212	
Bay Microsurgical Unit	Georgetown	1		1	3,465		3,465	3,465		
Murrell's Inlet Ambulatory Surgery Center	Georgetown	2		2						*8*
(Waccamaw Endoscopy Center)	Georgetown		(0)	(0)		1,915	1,915		1,915	*9*
Waccamaw Surgery Center	Georgetown	1		1	1,100		1,100	1,100		*10*
Carolina Bone and Joint Surgery Center	Horry	3		3	2,204		2,204	735		*11*
Grande Dunes Surgery Center	Horry	3	2	5	2,757	334	3,091	919	167	

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Ocean Ambulatory Surgery Center	Horry	2		2	1,925		1,925			*12*
Parkway Surgery Center	Horry	2		2	2,913		2,913	1,457		
Rivertown Surgery Center	Horry	3		3	824	732	1,556	275		
(Seacoast Med Ctr Ambulatory Surgery)	Horry	(0)		(0)	1,999	1,174	3,173	1,058		*13*
Strand GI Endoscopy Center	Horry		2	2		4,701	4,701		2,351	
Wesmark Ambulatory Surgery Facility	Sumter	2		2	2,834		2,834	1,417		
Region IV:										
Ambulatory Surgical Center of Aiken	Aiken	4	1	5	2,754	1,262	4,016	689	1,262	
Carolina Ambulatory Surgery Center	Aiken	1		1	2,945		2,945			
Bluffton-Okatie Outpatient Center	Beaufort	2	1	3	1,059	580	1,639	530	580	
Laser and Skin Surgery Center	Beaufort	2		2	1,149		1,149	575		
Outpatient Surgery Ctr. Hilton Head	Beaufort	3	2	5	3,418	2,265	5,683	1,709	1,133	*14*
Surgery Center of Beaufort	Beaufort	3		3	3,625	1,509	5,134	1,208		
Roper Hospital Ambulatory Surgery - Berkeley	Berkeley	3		3	298	432	730	99		
Charleston Endoscopy Center	Charleston		4	4		9,618	9,618		2,405	
Charleston Surgery Center	Charleston	4	1	5	5,259	1,472	6,731	1,315	1,472	
Colorectal EndoSurgery Institute of the Carolinas	Charleston		2	2						*15*
Elms Endoscopy Center	Charleston		3	3		6,472	6,472		2,157	
Lowcountry Ambulatory Center	Charleston	2		2						*16*

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Palmetto Endoscopy Center	Charleston		2	2		6,148	6,148		3,074	
Physicians' Eye Surgery Center	Charleston	4		4	4,812		4,812	2,406		*17*
Roper Hosp Ambulatory Surg & Pain Mgt - James Island	Charleston	4		4	3,628		3,628	907		
Roper St. Francis Eye Center	Charleston	3		3	146		146	49		*18*
Southeastern Spine Institute	Charleston	2		2	8,401		8,401	4,201		
Surgery Center of Charleston	Charleston	4		4	4,142	1,410	5,552	1,036	1,410	*19*
Trident Eye Surgery Center	Charleston	2		2	2,772		2,772	1,386		
Trident Surgery Center	Charleston	6		6	4,567	266	4,833	761		*20*
(West Ashley Endoscopy Center)	Charleston		(0)	(0)						*21*
Colleton Ambulatory Surgery Center	Colleton	2	1	3	942	472	1,414	471	472	
Lowcountry Outpatient Surgery Ctr.	Dorchester	2		2	2,901		2,901	1,451		
TOTALS		175	75	250	170,777	119,958	290,735	1,088	1,411	

Ambulatory Surgical Facility (ASF) Footnotes

--- No data available for facility during reporting period.

1 Formerly Upstate Pain Management.

2 CON issued 10/22/07 to add 2 additional ORs for a total of 4 ORs, SC-07-54. Licensed for 4 ORs 1/15/10. Formerly Spartanburg Urology Surgicenter.

3 Facility was de-licensed effective 2/28/11.

4 CON issued 5/13/11 to add 2 ORs for a total of 4, SC-11-11.

5 CON issued 12/9/10 to construct an ASF with 2 Endoscopy Suites restricted to gastroenterology procedures only, SC-10-38. Licensed 8/26/11.

6 CON denied to expand from 2 to 4 Endoscopy Suites 9/19/03; under appeal.

7 CON approved 2/26/07 for an ASF with 3 Endoscopy Suites restricted to gastroenterology procedures only; appealed. CON SC-08-18 issued 6/12/08. Licensed 2 of the Endoscopy Suites 6/26/09; licensed 3rd Endoscopy Suite 6/1/10.

8 CON issued 1/6/12 to establish an ASF with 2 ORs, SC-11-56.

9 Facility purchased by Georgetown Memorial Hospital with the intent of converting to a provider-based outpatient surgical department of the hospital. Closed effective 3/10/12.

10 Formerly Atlantic Surgery Center.

11 CON issued 7/15/10 to add a 3rd OR, SC-10-22. 3rd OR licensed 12/7/10.

12 Facility temporarily closed 8/12/11.

13 Facility was de-licensed effective 11/23/11.

14 CON issued 8/24/09 to add 1 OR for a total of 3 ORs and 2 Endoscopy Suites, SC-09-41. New OR licensed 3/22/10.

15 CON issued 6/3/11 to establish an ASF with 2 Endoscopy Suites, SC-11-20.

16 CON issued 11/28/11 for an ASF with 2 ORs, SC-11-48.

17 CON issued 7/29/11 to add 2 OR's for a total of 4, SC-11-26.

18 Formerly Roper West Ashley.

19 CON issued 5/13/11 to add 2 ORs and convert the existing endoscopy suite to an OR, for a total of 4 ORs, SC-11-16.

20 CON issued 12/9/10 to convert 2 procedures rooms to ORs for a total of 6 ORs, SC-10-36. Licensed for 6 ORs on 11/15/11.

21 CON approved 12/29/09; appealed. CON issued 5/3/10, SC-10-14. CON voided 6/16/11.

B. Emergency Hospital Services:

All hospital emergency departments are sub-categorized into four levels of service from I to IV, with I being the highest level of care. These categories are based on modified TJC standards and adopted by the State EMS Advisory Council. Each facility must comply with the following paragraphs corresponding to their designated level of care. These standards do not constitute Certificate of Need criteria. All segments of the population should have basic emergency services available within 30 minutes one-way travel time.

Level I: offers comprehensive emergency care 24 hours a day, with at least one physician experienced in emergency care on duty in the emergency care area. There is in-hospital physician coverage by members of the medical staff or by senior-level residents for at least medical, surgical, orthopedic, obstetric/gynecologic, pediatric, and anesthesia services. Other specialty consultation is available within approximately 30 minutes; initial consultation through two-way voice communication is acceptable.

Level II: offers emergency care 24 hours a day, with at least one physician experienced in emergency care on duty in the emergency care area, and with specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. The hospital's scope of services includes in-house capabilities for managing physical and related emotional problems, with provision for patient transfer to another organization when needed.

Level III: offers emergency care 24 hours a day, with at least one physician available to the emergency care area within approximately 30 minutes through a medical staff call roster. Specialty consultation is available by request of the attending medical staff member or by transfer to a designated hospital where definitive care can be provided.

Level IV: offers reasonable care in determining whether an emergency exists, renders lifesaving first aid, and makes appropriate referral to the nearest organization that is capable of providing needed services. The mechanism for providing physician coverage at all times is defined by the medical staff.

According to DHEC Health Licensing, the following facilities are considered to be freestanding emergency services (along with the hospital they are an extension of):

Moncks Corner Medical Center (Trident Medical Center) – Moncks Corner, Dorchester County
Seacoast Medical Center (Loris Community Hospital) – Little River, Horry County
South Strand Ambulatory Care Center (Grand Strand Regional) – Myrtle Beach, Horry County
Roper St. Francis Berkeley (Roper St. Francis) – Moncks Corner, Berkeley County
Roper St. Francis Northwoods (Roper St. Francis) – North Charleston, Charleston County

Certficate of Need Standards for Freestanding Emergency Services

(1) A Certificate of Need is required to establish a freestanding emergency service (also referred to as an off-campus emergency service).

(2) All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.

(3) Regulation 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries, Section 613, will be used to survey off-campus emergency services, specifically including 24 hour/7 day per week physician coverage on site.

(4) An off-campus emergency service must have written agreements with Emergency Medical Services providers and surrounding hospitals regarding serious medical problems, which the off-campus emergency service cannot handle.

(5) The physical structure must meet Section 12-6 of the Life Safety Code, New Ambulatory Health Care Centers and must specifically have an approved sprinkler system.

(6) The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Resource Availability; and
d. Financial Feasibility.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

C. Trauma Referral System:

Trauma centers are designed and equipped to handle complex injuries. In 1990, there were 1,125 trauma centers nationwide. By 2005, about 30 percent of them had closed (339). A recent study has determined that a quarter of all Americans had to travel further to a trauma center in 2007 than they did in 2001. The median travel time increased by 10 minutes, which is significant when the first hour after injury is vital for severe injury victims (the so-called "golden hour").

The DHEC Division of Emergency Medical Services has developed and implemented a trauma referral system throughout the state. This system allows any hospital desiring and qualifying as a trauma center to become so designated. The summary definitions below were derived from the American College of Surgeons criteria. The following is a brief description of the criteria for each of the three levels of Trauma Centers. Emergency departments in all trauma centers are required to have adequate staff to include Emergency Department physicians in-house 24 hours per day.

Level I: The highest level of capability available. Generally speaking, this hospital has to have general surgery capability in-house at all times. Anesthesia capabilities are required to be in-house at all times, but this requirement may be met with CRNA's or anesthesiology chief residents. Orthopedic surgery, neurological surgery, and other surgical and medical specialties must be immediately available. Generally, these trauma centers will be attached to medical schools or will have residency programs because of the in-house requirements, since fourth year and senior trauma residents can help meet the requirements of the Level I criteria. The Level I Trauma Center also has the responsibility of providing education and outreach programs to other area hospitals and the public and must also conduct trauma-related research.

Level II: This hospital has extensive capability and meets the needs of most trauma victims. It is required to have general, neurological and orthopedic surgery available when the patient arrives. Anesthesiology capabilities are required to be in-house at all times, but this requirement may be met with CRNA's. Other surgical and medical specialties are required to be on-call and promptly available. These hospitals may develop local procedures for the surgeons being available in the Emergency Department when the patient arrives. The primary difference between Level I and II facilities is that the major surgical specialties are allowed to be on-call in Level II trauma centers but with the clear commitment to be in the Emergency Department when the patient arrives. Level II hospitals do not have the research requirements of a Level I trauma center.

Level III: This hospital is committed to caring for the trauma patient. Level III trauma centers can provide prompt assessment, resuscitation, emergency operations, and stabilization, and also arrange for possible transfer of the patient to a facility that can provide definitive trauma care. These hospitals are required to have general surgery, anesthesia, and radiology on-call and promptly available. The general surgeon is required to be on-call and promptly available in the Emergency Department as the trauma team leader.

CHAPTER XII

LONG TERM CARE FACILITIES AND SERVICES

A. Nursing Facilities:

Nursing facilities provide inpatient care for convalescent or chronic disease residents who require nursing care and related medical services. Such nursing care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the State. Facilities furnishing primarily domiciliary care are not included. Under www.scdhec.gov the licensing list of nursing facilities also denotes the facilities that have Alzheimer's units. For more specific detail about nursing facilities, refer to Regulation 61-17, Standards for Licensing Nursing Homes.

A ratio of 39 beds/1,000 population age 65 and over is used to project the need for 2014. Since the vast majority of patients utilizing nursing facilities are 65 years of age or older, only this segment of the population is used in the need calculations. A two-year projection is used because nursing facilities can be constructed and become operational in two years.

Certificate of Need Standards

1. Bed need is calculated on a county basis. Additional beds may be approved in counties with a positive bed need up to the need indicated.

2. When a county shows excess beds, additional beds will not be approved, except to allow an individual nursing facility to add some additional beds in order to make more economical nursing units. These additions are envisioned as small increments in order to increase the efficiency of the nursing home. This exception for additional beds will not be approved if it results in a three bed ward. A nursing facility may add up to 16 additional beds per nursing unit to create either 44 or 60 bed nursing units, regardless of the projected bed need for the county. The nursing facility must document how these additional beds will make a more economical unit(s).

3. Some Institutional Nursing Facilities (see Chapter XII E.) are dually licensed, with some beds restricted to residents of the retirement community and the remaining beds are available to the general public. The beds restricted to residents of the retirement community are not eligible to be certified for Medicare or Medicaid. Should such a facility have restricted beds that are inadvertently certified, the facility will be allowed to apply for a Certificate of Need to convert these beds to general nursing home beds, regardless of the projected bed need for that county.

The following pages depict the calculation of long-term care bed need and the current ratio of beds per thousand aged 65 and over by county. The following map depicts the number of additional beds needed or the number of excess beds (circled) by county.

Quality

CMS has established the 5-Star Quality Rating System for nursing facilities. It gives consumers the opportunity to see how different nursing facilities have rated on measurements of quality. The system gives each Medicare/Medicaid-participating nursing facility between 1-5 stars with 5 having the highest overall quality and 1 the lowest. This overall score is based on 3 components, each of which is also individually rated. These are:

a. Health inspections – from the past 3 years plus any complaint investigations.
b. Staffing ratios – the number of nursing hours of staff per patient per day, adjusted by the level of need of the patients.
c. Quality measures – 10 physical and clinical measures of patient care, such as incidence of bed sores and changes in mobility.

The system is accessible online and allows the user to compare multiple facilities at the same time. The URL is: http://www.medicare.gov/NHCompare

The Department may use the 5-Star data in evaluating a CON application for additional nursing facility beds at an existing facility.

In addition, the National Quality Forum (NQF) has proposed a series of new quality measures related to the types of care provided, current health status and changes in health status, and patient and family satisfaction. Of the 21 measures:

a. Four relate to pneumonia and flu vaccines.
b. Three each relate to pain, consumer satisfaction, and bladder/urinary/bowels.
c. Two relate to pressure ulcers.
d. The remainder relate to patient falls, restraints, weight loss, depression, help needed for daily living, and physical therapy or rehabilitative care.

Relative Importance of Project Review Criteria

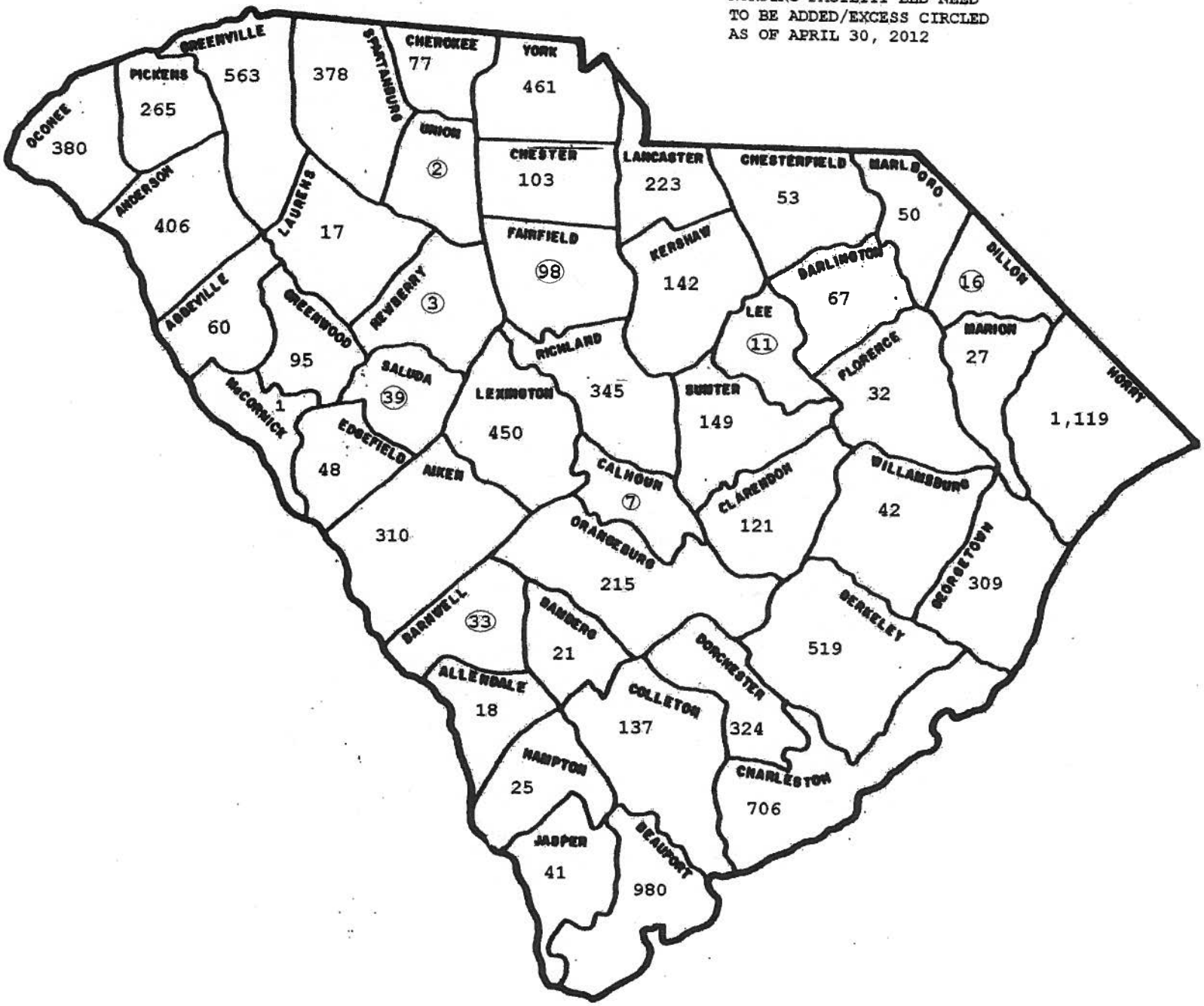
The following project review criteria are considered the most important in evaluating Certificate of Need applications for these beds or facilities:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Projected Revenues;
c. Projected Expenses;
d. Net Income;
e. Methods of Financing;
f. Financial Feasibility;
g. Record of the Applicant; and
h. Distribution (Accessibility).

LONG TERM CARE BED NEED

		2014 POP. 65+(000)	BED NEED (POP.X 39)	EXISTING BEDS	BEDS NEEDED/ EXCESS	TOTAL # BEDS TO BE ADDED
	ANDERSON	31.20	1,217	811	406	406
	CHEROKEE	8.20	320	243	77	77
	GREENVILLE	64.10	2,500	1,937	563	563
	OCONEE	16.20	632	252	380	380
	PICKENS	18.00	702	437	265	265
	SPARTANBURG	42.80	1,669	1,291	378	378
	UNION	5.10	199	201	-2	
REGION I	TOTAL	185.60	7,239	5,172	2,067	2,069
	ABBEVILLE	4.50	176	116	60	60
	CHESTER	5.20	203	100	103	103
	EDGEFIELD	4.30	168	120	48	48
	FAIRFIELD	4.20	164	262	-98	
	GREENWOOD	11.50	449	354	95	95
	KERSHAW	9.90	386	244	142	142
	LANCASTER	13.10	511	288	223	223
	LAURENS	11.20	437	420	17	17
	LEXINGTON	37.60	1,466	1,016	450	450
	MCCORMICK	3.10	121	120	1	1
	NEWBERRY	6.70	261	264	-3	
	RICHLAND	43.50	1,697	1,352	345	345
	SALUDA	3.50	137	176	-39	
	YORK	29.60	1,154	693	461	461
REGION II	TOTAL	187.90	7,330	5,525	1,805	1,945
	CHESTERFIELD	7.10	277	224	53	53
	CLARENDON	7.00	273	152	121	121
	DARLINGTON	11.10	433	366	67	67
	DILLON	4.60	179	195	-16	
	FLORENCE	20.70	807	775	32	32
	GEORGETOWN	14.30	558	249	309	309
	HORRY	54.70	2,133	1,014	1,119	1,119
	LEE	2.80	109	120	-11	
	MARION	5.30	207	180	27	27
	MARLBORO	4.10	160	110	50	50
	SUMTER	15.50	605	456	149	149
	WILLIAMSBURG	5.80	226	184	42	42
REGION III	TOTAL	153.00	5,967	4,025	1,942	1,969
	AIKEN	27.90	1,088	778	310	310
	ALLENDALE	1.60	62	44	18	18
	BAMBERG	2.80	109	88	21	21
	BARNWELL	3.60	140	173	-33	
	BEAUFORT	40.80	1,591	611	980	980
	BERKELEY	22.40	874	355	519	519
	CALHOUN	2.90	113	120	-7	
	CHARLESTON	51.40	2,005	1,299	706	706
	COLLETON	6.90	269	132	137	137
	DORCHESTER	17.30	675	351	324	324
	HAMPTON	3.30	129	104	25	25
	JASPER	3.30	129	88	41	41
	ORANGEBURG	15.60	608	393	215	215
REGION IV	TOTAL	199.80	7,792	4,536	3,256	3,296
STATEWIDE TOTALS		726.30	28,328	19,258	9,070	9,279

NURSING FACILITY BED NEED
TO BE ADDED/EXCESS CIRCLED
AS OF APRIL 30, 2012



COUNTY	2014 POP (000s 65+)	NURSING FACILITY BEDS	BEDS PER 1,000 POP	RANK
BEAUFORT	40.80	611	14.98	1
OCONEE	16.20	252	15.56	2
BERKELEY	22.40	355	15.85	3
GEORGETOWN	14.30	249	17.41	4
HORRY	54.70	1,014	18.54	5
COLLETON	6.90	132	19.13	6
CHESTER	5.20	100	19.23	7
DORCHESTER	17.30	351	20.29	8
CLARENDON	7.00	152	21.71	9
LANCASTER	13.10	288	21.98	10
YORK	29.60	693	23.41	11
PICKENS	18.00	437	24.28	12
KERSHAW	9.90	244	24.65	13
ORANGEBURG	15.60	393	25.19	14
CHARLESTON	51.40	1,299	25.27	15
ABBEVILLE	4.50	116	25.78	16
ANDERSON	31.20	811	25.99	17
JASPER	3.30	88	26.67	18
MARLBORO	4.10	110	26.83	19
LEXINGTON	37.60	1,016	27.02	20
ALLENDALE	1.60	44	27.50	21
AIKEN	27.90	778	27.89	22
EDGEFIELD	4.30	120	27.91	23
SUMTER	15.50	456	29.42	24
CHEROKEE	8.20	243	29.63	25
SPARTANBURG	42.80	1,291	30.16	26
GREENVILLE	64.10	1,937	30.22	27
GREENWOOD	11.50	354	30.78	28
RICHLAND	43.50	1,352	31.08	29
BAMBERG	2.80	88	31.43	30
HAMPTON	3.30	104	31.52	31
CHESTERFIELD	7.10	224	31.55	32
WILLIAMSBURG	5.80	184	31.72	33
DARLINGTON	11.10	366	32.97	34
MARION	5.30	180	33.96	35
FLORENCE	20.70	775	37.44	36
LAURENS	11.20	420	37.50	37
MCCORMICK	3.10	120	38.71	38
NEWBERRY	6.70	264	39.40	39
UNION	5.10	201	39.41	40
CALHOUN	2.90	120	41.38	41
DILLON	4.60	195	42.39	42
LEE	2.80	120	42.86	43
BARNWELL	3.60	173	48.06	44
SALUDA	3.50	176	50.29	45
FAIRFIELD	4.20	262	62.38	46
	726.30	19,258	26.52	

Because nursing facilities are located within approximately thirty (30) minutes travel time for the majority of the residents of the State and at least one nursing facility is located in every county, no justification exists for approving additional nursing facilities or beds that are not indicated as needed in this Plan. The major accessibility problem is caused by the lack of Medicaid funding since the Medicaid Program pays for approximately 65% of all nursing facility residents. This Plan projects the need for nursing facility beds by county. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing beds or the placement of Medicaid funds for the beds.

B. Medicaid Nursing Home Permits:

Beginning July 1, 1988, nursing facilities that wish to continue to serve Medicaid residents must apply to the Department for a Medicaid nursing home permit. The permit will state how many Medicaid patient days the nursing facility may provide, and the nursing facility must provide within 10 percent of this number of days of care. As mandated by the Nursing Home Licensing Act of 1987, as amended, the Department will allocate permits up to the number of Medicaid patient days authorized by the General Assembly.

Medicaid Patient Days and Medicaid Beds Requested and Authorized:

Year	# Days Requested	Beds	# Days Authorized	Beds	# Days Difference
1988-1989	3,032,839	8,309	2,971,811	8,142	61,028
1989-1990	3,644,248	9,984	3,644,248	9,984	0
1990-1991	3,709,814	10,163	3,659,965	10,028	49,849
1991-1992	3,856,833	10.567	3,659,965	10,028	196,868
1992-1993	3,976,576	10,895	3,806,382	10,429	170,194
1993-1994	4,012,359	10,993	3,856,382	10,566	155,977
1994-1995	4,023,690	11,024	3,892,882	10,665	130,808
1995-1996	3,969,681	10,876	3,892,882	10,665	76,799
1996-1997	4,072,519	11,158	4,002,382	10,965	70,137
1997-1998	4,119,753	11,287	4,097,282	11,225	22,471
1998-1999	4,265,182	11,685	4,265,182	11,685	0
1999-2000	4,367,134	11,965	4,341,832	11,895	25,302
2000-2001	4,420,522	12,111	4,378,332	11,995	42,190
2001-2002	4,473,170	12,255	4,275,998	11,715	197,172
2002-2003	4,340,158	11,891	4,205,553	11,522	134,605
2003-2004	4,304,160	11,792	4,205,553	11,522	98,607
2004-2005	4,294,977	11,767	4,205,553	11,522	89,424
2005-2006	4,291,812	11,758	4,205,553	11,522	86,259
2006-2007	4,283,209	11,735	4,205,553	11,522	77,656
2007-2008	4,263,785	11,682	4,205,553	11,522	58,232
2008-2009	4,231,047	11,592	4,205,553	11,522	25,494
2009-2010	4,215,522	11,549	4,205,553	11,522	9,969
2010-2011	4,217,584	11,555	4,205,553	11,522	12,031
2011-2012	4,250,190	11,644	3,771,878	10,333	478,312

C. Community Long Term Care (CLTC) Program:

The South Carolina Community Long Term Care Project (CLTC) provides mandatory pre-admission screening and case management for Medicaid-eligible individuals who are applying for nursing facility placement under the Medicaid program. It also provides the following community-based services for participants who prefer to receive care in the community rather than institutional care:

a. Personal Care;
b. Environmental Modifications;
c. Home-Delivered Meals;
d. Adult Day Health Care (ADHE);
e. Respite Care;
f. Personal Emergency Response System (PERS);
g. Durable Medical Equipment;
h. Nursing Services; and
i. Case Management.

DHHS operates three home and community-based Medicaid waiver programs through the CLTC program. The Community Choices program served around 13,000 patients in FY 09-10; DHHS projected the daily cost of this program as $32 versus $127 for nursing home care. The other waivers served about 900 persons with HIV disease and approximately 1,300 adults who are dependent upon mechanical ventilation. The PACE program is jointly funded by Medicare and provides primary and long-term care services to participants age 55 and older who meet the State's nursing facility level of care. The Palmetto SeniorCare (PSC) Program operates four PACE Centers in Richland and Lexington Counties and serves approximately 365 participants annually. The only other PACE site in South Carolina is operated by The Oaks CCRC in Orangeburg. DHHS is also participating in a federal initiative called Money Follows the Person (MFP), which allows people who have been in a nursing facility for at least six months to transition back to the community.

D. Mental Retardation Facilities:

According to national estimates, three percent of the population is considered to be mentally retarded and one percent is retarded to the extent that special support services and programs are needed.

The South Carolina Department of Disabilities and Special Needs (DDSN) has reduced the bed capacity of its four regional centers (Whitten, Coastal, Midlands, and Pee Dee). Community residential beds have been developed for those persons from the regional centers and those on the residential services waiting list. These beds represent the continuum of programs, which includes community residences, supervised living programs, and community training homes. These programs enable persons with mental retardation to be served in their own communities in the settings they choose to live and receive supports in. DDSN also operates three home and community-based Medicaid waiver programs for the following target groups: Mental Retardation and Related Disabilities, Head and Spinal Cord Injuries, and Pervasive Developmental Disorders.

E. Institutional Nursing Facility (Retirement Community Nursing Facility):

An institutional nursing facility means a nursing facility (established within the jurisdiction of a larger non-medical institution) that maintains and operates organized facilities and services to accommodate only students, residents or inmates of the institution. A bed need for this category has been established in order to provide necessary services for retirement communities as established by church, fraternal, or other organizations. Such beds must serve only the residents of the housing complex and either be developed after the housing has been established or be developed as a part of a total housing construction program that has documented that the entire complex is one inseparable project.

To be considered under this special bed category, the following criteria must be met:

(1) The nursing facility must be a part of and located on the campus of the retirement community.

(2) It must restrict admissions to campus residents.

(3) The facility may not participate in the Medicaid program.

There is no projection of need for this bed category. The applicant must demonstrate that the proposed number of beds is justified and that the facility meets the above qualifications. If approved by the Department, such a facility would be licensed as an "Institutional Nursing Home," and the beds generated by such a project will be placed in the statewide inventory in Chapter III. These beds are not counted against the projected need of the county where the facility is located. For established retirement communities, a generally accepted ratio of nursing facility beds to retirement beds is 1:4. However, this ratio may high for a newly established retirement center as new residents are typically not in need of nursing facility care as soon as the facility is licensed. The nursing facility could operate at low utilization for the first several years.

Relative Importance of Project Review Criteria

The following project review criteria, as outlined in Chapter 8 of Regulation 61-15, are considered the most important in evaluating Certificate of Need applications for these beds or facilities:

a. Need for the Proposed Project;
b. Economic Consideration; and
c. Health System Resources.

Because Institutional Nursing Facility Beds are used solely by the residents of the retirement community, there is no justification for approving this type of nursing facility unless the need can be documented by the retirement center. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing beds or facilities.

F. Swing Beds:

A Certificate of Need is not required to participate in the Swing Bed Program in South Carolina. However, the hospital must be certified to participate in Medicare.

The Social Security Act (Section 1883(a)(1), [42 U.S.C. 1395tt] permits certain small, rural hospitals to enter into a swing bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. The hospital must be located in a rural area and have fewer than 100 beds. The Code of Federal Regulations (CFR) section 42 details the other specific program requirements

Medicare Part A covers the services furnished in a swing bed hospital under the SNF PPS. The PPS classifies residents into one of 44 categories for payment purposes. To qualify for SNF-level services, a beneficiary is required to receive acute care as a hospital inpatient for a stay of at least three consecutive days, although it does not have to be from the same hospital as the swing bed. Typical medical criteria include daily physical, occupational and/or speech therapy, IV or nutritional therapy, complex wound treatment, pain management, and end-of-life care.

The following hospitals in South Carolina participated in the swing bed program during 2010:

Hospital		Swing Beds	Admissions	Patient Days	Average Census
Abbeville Area Medical Ctr.		25	37	227	0.6
Allendale County Hospital		15	105	3,690	10.1
Bamberg County Memorial		24	60	682	1.9
Chesterfield General		49	84	831	2.3
Coastal Carolina		10	7	49	0.1
Edgefield Co. Hospital		25	81	1,193	3.3
Fairfield Memorial		25	76	725	2.0
Hampton Regional Hospital	*1*	10			
Marlboro Park Hospital		6	54	242	0.7
McLeod-Darlington		24	109	4,736	13.0
Newberry County Memorial	*2*	20			
Wallace Thompson	*2*	12			
Williamsburg Regional		10	92	1,341	3.7
TOTALS		255	705	13,716	37.6

1 Unit established 9/28/11.
2 Participates in the program but did not use the beds in 2010.

G. Hospice Facilities and Hospice Programs:

Hospice is a centrally administered, interdisciplinary health care program, which provides a continuum of medically supervised palliative and supportive care for the terminally ill patient and the family or responsible party, including, but not limited to home, outpatient and inpatient services provided directly or through written agreement. Inpatient services include, but are not limited to, services provided by a hospice in a licensed hospice facility.

A Hospice Facility means an institution, place or building licensed by the Department to provide room, board and appropriate hospice care on a 24-hour basis to individuals requiring such services pursuant to the orders of a physician.

A Hospice Program means an entity licensed by the Department that provides appropriate hospice care to individuals as described in the first paragraph above, exclusive of the services provided by a hospice facility.

The existing and approved inpatient hospices in South Carolina are listed on the following page.

Certificate of Need Standards

1. A Certificate of Need is only required for an Inpatient Hospice Facility; it is not required for the establishment of a Hospice Program.

2. An Inpatient Hospice Facility must be owned or operated either directly or through contractual agreement with a licensed hospice program.

3. The applicant must document the need for the facility and justify the number of inpatient beds that are being requested.

4. The proposed facility must consider the impact on other existing inpatient hospice facilities.

Relative Importance of Project Review Criteria

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Community Need Documentation;
d. Acceptability;
e. Financial feasibility; and
f. Staff Resources.

Ninety-eight licensed Hospice Programs exist with at least one licensed hospice serving every county in the state. Additional information may be found at http://www.scdhec.net/health/hrreg.htm. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

NAME OF FACILITY		COUNTY	LICENSED BEDS	ADMISSIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
REGION I							
CALLIE & JOHN RAINEY HOSPICE HOUSE		ANDERSON	32	667	8,739	32	74.8%
MCCALL HOSPICE HOUSE OF GREENVILLE		GREENVILLE	30	681	8,257	30	75.4%
OCONEE MEMORIAL HOSPICE FOOTHILLS		OCONEE	15	264	3,737	15	68.3%
HOSPICE HOUSE OF CAROLINA FOOTHILLS		SPARTANBURG	12	195	2,226	12	50.8%
SPARTANBURG REG HEALTHCARE HOSPICE		SPARTANBURG	15	534	4,645	15	84.8%
TOTAL			104	2,341	27,604	104	72.7%
REGION II							
HOSPICE HOUSE OF HOSPICECARE PIEDMONT		GREENWOOD	15	296	2,651	15	48.4%
HOSPICE OF LAURENS CO INPT HOSPICE HOUSE		LAURENS	12	109	1,611	12	36.8%
(ASCENSION HOUSE)	*1*	RICHLAND	(14)				
AGAPE HOSPICE HOUSE OF THE MIDLANDS	*2*	RICHLAND	12				
HOSPICE AND COMMUNITY CARE HOUSE		YORK	16	225	1,937	16	33.2%
TOTAL			55	630	6,199	43.0	39.5%
REGION III							
MCLEOD HOSPICE HOUSE	*3*	FLORENCE	24	566	3,858	12	88.1%
TIDELANDS COMMUNITY HOSPICE HOUSE		GEORGETOWN	12	222	2,203	12	50.3%
AGAPE HOSPICE HOUSE OF HORRY COUNTY	*4*	HORRY	(24)				
MERCY CARE HOSPICE HOUSE CONWAY	*5*	HORRY	14			---	
TOTAL			50	788	6,061	24	69.2%
REGION IV							
HOSPICE CTR HOSPICE OF CHARLESTON		CHARLESTON	20	461	2,978	20	40.8%
TOTAL			20	461	2,978	20	40.8%
STATEWIDE TOTAL			**229**	**4,220**	**42,842**	**191**	**61.5%**

1 FACILITY CLOSED 1/1/11; UTILIZATION DATA NOT AVAILABLE FOR 2010.

2 CON ISSUED 5/13/11 TO ESTABLISH A 12 BED INPATIENT HOSPICE, SC-11-14.

3 CON ISSUED 3/11/10 TO ADD 12 BEDS FOR A TOTAL OF 24, SC-10-10.

4 CON ISSUED 7/15/10 TO CONVERT THE INPATIENT HOSPICE BEDS TO NURSING HOME BEDS, SC-10-21.

5 CON APPROVED 12/28/11 FOR A 14 BED INPATIENT HOSPICE; APPEALED.

H. Home Health

1. Home Health Agencies:

Home Health Agency means a public, nonprofit, or proprietary organization, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services. Home health services means those items and services furnished to an individual by a home health agency, or by others under arrangement with the home health agency, on a visiting basis and except for (f) below, in a place of temporary or permanent residence used as the individual's home as follows:

Part-time or intermittent skilled nursing care as ordered by a physician or podiatrist and provided by or under the supervision of a registered nurse and at least one other therapeutic service listed below: (a) physical, occupational, or speech therapy; (b) medical social services; (c) home health aide services; (d) other therapeutic services; (e) medical supplies as indicated in the treatment plan and the use of medical appliances, to include durable medical equipment and (f) any of the above items and services provided on an outpatient basis under arrangements made by the home health agency with a hospital, nursing home or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items/services cannot readily be made available to the individual in his/her home, or which are furnished at one of the above facilities while the patient is there to receive such items or services. Transportation of the individual in connection with any such items or services is not included.

The mix of home health visits by type of service during FY 2010 for the home health agencies in South Carolina was:

Total Visits	2,067,406
Nursing Visits	44.4%
Physical Therapy Visits	34.7%
Occupational Therapy Visits	9.4%
Home Health Aide Visits	7.5%
Speech Therapy Visits	1.8%
Medical Social Worker Visits	1.7%
Other	0.5%

Nursing visits includes all visits provided by a nurse including IV therapy and chemotherapy.

Under the Balanced Budget Act of 1997, Medicare changed to a Prospective Payment System (PPS) for home health services. Patients are assessed and assigned to one of 80 Home Health Resource Groups (HHRGs); agencies then receive a fixed payment for a 60-day episode of care, regardless of the number of visits provided. As a result, the number of visits per patient has decreased from 45.7 in 1997 to 20.5 in 2010.

Of the patients currently receiving home health services, about 2% are age 17 and under, approximately 32% are age 18-64, 22% are age 65-74, and almost 44% are 75 and over. Some agencies are licensed to serve broad geographic areas, yet provide services to less than 50 patients annually in some counties in their licensed service area. Unless a need for another agency is indicated, the existing agencies should be able to expand their staff to meet any additional need.

Certificate of Need Standards

1. An applicant must propose home health services to cover the geographic area of an entire county and agree to serve residents throughout the entire county.

2. A separate application is required for each county in which services are to be provided.

3. It is recommended that an application for a new home health agency should contain letters of support from physicians in the proposed service area.

4. The need methodology creates statewide use rates for four population groups (0-14, 15-64, 65-74, 75+) based on 2010 utilization data; 75% of these rates are applied against the projected 2012 populations for each county to get a total number of estimated patients in need. It then takes the actual number of patients served in 2009 and multiplies them by the population growth factor to project the number of patients to be served by the existing home health agencies in the county for 2012. The projected number of patients served by the existing agencies is subtracted from the total estimated number of patients in need. If there is a difference of 100 or more patients projected to be in need, then another agency could be approved for that county.

5. Before an application for a new home health agency can be accepted for filing, all existing agencies in the county where the proposed facility is to be located must have been licensed and operational for an entire year, and must have submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The data will not be prorated or projected into the future but based on actual utilization.

6. The applicant should have a track record that demonstrates a commitment to quality services. There should be no history of prosecution, loss of license, consent order, or abandonment of patients in other business operations. The applicant must provide a list of all licensed home health agencies it operates and the state(s) where it operates them.

7. The applicant must document that it can serve at least 50 patients annually in each county for which it is licensed within two years of initiation of services. The applicant must assure the Department that, should they fail to provide home

HOME HEALTH METHODOLOGY

County	Projected Pop 2012 Age 0-17	2012 Estimated Pts Age 0 - 17	Projected Pop 2012 Age 18-64	2012 Estimated Pts Age 18 - 64	Projected Pop 2012 Age 65-74	2012 Estimated Pts Age 65 - 74	Projected Pop 2012 Age 75+	2012 Estimated Pts Age 75+	Total Estimated 2012 Patients	2010 Actual Patients	Population Growth Factor	Total Projected 2012 Patients	2012 Unmet (Need)/ Surplus	Need at 100 Patients	New Agency Approved Since 12/31/09	New Agency Can be Approved
Abbeville	5,800	6	15,500	125	2,600	118	1,700	211	460	774	1.007	780	319	-----	-----	-----
Aiken	36,900	36	100,900	817	15,800	717	10,500	1,304	2,874	2,561	1.025	2,625	(248)	YES	YES	-----
Allendale	2,300	2	6,700	54	900	41	600	74	172	111	1.008	111	(61)	-----	-----	-----
Anderson	45,200	44	115,700	937	17,600	799	12,200	1,515	3,294	3,613	1.019	3,682	388	-----	-----	-----
Bamberg	3,500	3	9,600	78	1,600	73	1,100	137	290	301	0.989	298	7	-----	-----	-----
Barnwell	5,800	6	13,800	112	2,000	91	1,400	174	382	490	1.017	498	116	-----	-----	-----
Beaufort	33,800	33	97,200	787	22,800	1,035	14,300	1,775	3,630	3,595	1.036	3,725	95	-----	-----	-----
Berkeley	45,600	44	116,500	943	13,200	599	6,900	857	2,443	2,706	1.025	2,772	329	-----	-----	-----
Calhoun	3,300	3	9,500	77	1,700	77	1,000	124	281	340	1.021	347	66	-----	-----	-----
Charleston	73,400	71	232,100	1,879	28,000	1,271	19,900	2,471	5,692	9,212	1.009	9,296	3,604	-----	-----	-----
Cherokee	13,800	13	34,900	283	4,800	218	3,000	372	886	1,316	1.021	1,344	457	-----	-----	-----
Chester	8,000	8	20,500	166	3,100	141	2,000	248	563	995	1.014	1,009	446	-----	-----	-----
Chesterfield	11,600	11	29,000	235	4,200	191	2,500	310	747	833	1.012	843	96	-----	-----	-----
Clarendon	7,800	8	21,200	172	4,100	186	2,300	286	651	732	1.012	741	90	-----	-----	-----
Colleton	9,600	9	23,500	190	4,000	182	2,500	310	692	1,113	1.018	1,133	442	-----	-----	-----
Darlington	16,500	16	42,400	343	6,400	291	4,000	497	1,146	1,269	1.009	1,280	134	-----	-----	-----
Dillon	8,500	8	19,300	156	2,600	118	1,800	223	506	712	1.004	715	209	-----	-----	-----
Dorchester	37,200	36	87,500	708	9,900	449	5,700	708	1,902	2,565	1.027	2,635	734	-----	-----	-----
Edgefield	5,800	6	18,100	147	2,500	113	1,400	174	439	338	1.030	348	(91)	-----	-----	-----
Fairfield	5,400	5	15,000	121	2,400	109	1,500	186	422	588	1.014	596	175	-----	-----	-----
Florence	33,800	33	85,600	693	11,800	536	7,600	944	2,205	2,790	1.014	2,829	624	-----	-----	-----
Georgetown	12,900	12	35,500	287	8,300	377	4,800	596	1,273	2,080	1.022	2,126	854	-----	-----	-----
Greenville	110,100	107	290,500	2,352	35,900	1,630	24,900	3,091	7,180	8,080	1.023	8,262	1,082	-----	-----	-----
Greenwood	16,600	16	43,100	349	6,000	272	5,000	621	1,258	2,021	1.015	2,051	793	-----	-----	-----
Hampton	5,100	5	13,300	108	1,900	86	1,200	149	348	497	1.019	507	159	-----	-----	-----
Horry	54,500	53	174,500	1,413	31,600	1,435	18,900	2,346	5,247	6,784	1.038	7,041	1,795	-----	-----	-----
Jasper	6,100	6	16,300	132	1,900	86	1,200	149	373	470	1.029	484	111	-----	-----	-----
Kershaw	15,300	15	38,500	312	5,700	259	3,600	447	1,032	1,656	1.023	1,694	661	-----	-----	-----
Lancaster	17,800	17	47,400	384	7,800	354	4,600	571	1,326	1,700	1.012	1,721	395	-----	-----	-----
Laurens	15,400	15	42,000	340	6,100	277	4,500	559	1,191	1,888	1.022	1,930	739	-----	-----	-----
Lee	4,300	4	12,400	100	1,600	73	1,100	137	314	393	1.009	397	83	-----	-----	-----
Lexington	64,700	63	170,900	1,384	21,200	962	13,700	1,701	4,110	5,104	1.031	5,262	1,152	-----	-----	-----
Marion	8,000	8	20,200	164	3,200	145	1,800	223	540	697	1.004	700	160	-----	-----	-----
Marlboro	6,300	6	18,500	150	2,500	113	1,400	174	443	603	0.992	598	155	-----	-----	-----
McCormick	1,400	1	6,200	50	1,900	86	900	112	250	282	1.016	287	37	-----	-----	-----
Newberry	8,600	8	23,100	187	3,700	168	2,600	323	686	978	1.013	991	305	-----	-----	-----
Oconee	15,800	15	45,100	365	9,100	413	6,100	757	1,551	1,933	1.025	1,981	430	-----	-----	-----
Orangeburg	21,500	21	57,400	465	8,700	395	5,900	732	1,613	3,234	1.029	3,328	1,715	-----	-----	-----
Pickens	24,600	24	80,600	653	9,900	449	7,100	881	2,007	2,399	1.025	2,459	452	-----	-----	-----
Richland	88,200	85	261,700	2,119	24,200	1,099	16,200	2,011	5,314	6,004	1.015	6,095	781	-----	-----	-----
Saluda	4,600	4	12,200	99	2,000	91	1,400	174	368	313	1.016	318	(50)	-----	-----	-----
Spartanburg	69,800	68	179,500	1,453	24,200	1,099	16,300	2,024	4,643	6,053	1.019	6,170	1,527	-----	-----	-----
Sumter	27,700	27	66,500	538	8,600	390	6,100	757	1,713	3,041	1.013	3,082	1,369	-----	-----	-----
Union	6,600	6	17,400	141	2,800	127	2,100	261	535	827	0.998	825	290	-----	-----	-----
Williamsburg	8,000	8	21,000	170	3,300	150	2,100	261	588	948	0.999	947	359	-----	-----	-----
York	58,000	56	147,300	1,193	17,000	772	10,600	1,316	3,337	3,748	1.030	3,861	525	-----	-----	-----
TOTAL	1,085,500	1,051	2,955,600	23,929	411,100	18,664	268,000	33,272	76,916	98,687	1.021	100,723	23,807			

health services to fewer than 50 patients annually for a county two years after initiation of services, they will voluntarily relinquish the license for that county. If an agency's license is terminated, another agency will be approved only if the methodology indicates the projected need for an additional agency.

Quality

CMS initiated a national home health quality improvement campaign in January 2010. The Home Health Quality Improvement (HHQI) initiative is designed to reduce avoidable hospitalizations and improve medication management. The campaign will provide resources and best practice education to participating HHAs. The South Carolina Home Care & Hospice Association (SCHCA) is serving as the Local Area Network for Excellence (LANE) to create campaign awareness and recruit participants.

While this is a voluntary campaign, the Department encourages all licensed Home Health Agencies to participate.

Relative Importance of Project Review Criteria

The following project review criteria, as outlined in Chapter 8 of Regulation 61-15, are considered to be the most important in reviewing CON applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Acceptability;
c. Distribution (Accessibility);
d. Medically Underserved Groups;
e. Record of the Applicant; and
f. Financial Feasibility.

Because home health agencies provide services in every county and there are at least two providers per county, there is no justification for approving additional agencies beyond those shown as needed in this Plan. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing service.

2. Pediatric Home Health Agencies:

Due to the limited number of home health providers available to treat children 18 years or younger, an exception to the above criteria may be made for a CON for a Home Health Agency restricted to providing intermittent home health skilled nursing services to patients 18 years or younger. The license for the agency will be restricted to serving children 18 years or younger and will ensure access to necessary and appropriate intermittent home health skilled nursing services to these patients. Any such approved agency will not be counted in the county inventories for need projection purposes.

Certificate of Need Standards

1. A separate CON application will be required for each county for an agency that proposes to provide this specialized service to pediatric patients in multiple counties.

2. The applicant must document that there is an unmet need for this service in the county of application, and the agency will limit such services to the pediatric population 18 years or younger.

3. The applicant must document the full range of services (RN, PT, ST, MSW, IV, etc.) that they intend to provide to pediatric patients.

3. Continuing Care Retirement Community Home Health Agencies:

A licensed continuing care retirement community that also incorporates a skilled nursing facility may provide home health services and is exempt from Certificate of Need provided:

1. The continuing care retirement furnishes or offers to furnish home health services only to residents who reside in living units provided by the continuing care retirement community pursuant to a continuing care contract;

2. The continuing care retirement community maintains a current license and meets the applicable home health agency licensing standards; and

3. Residents of the continuing care retirement community may choose to obtain home health services from other licensed home health agencies.

Staff from other areas of the continuing care retirement community may deliver the home health services, but at no time may staffing levels in any area of the continuing care retirement community fall below minimum licensing standards or impair the services provided. If the continuing care retirement community includes charges for home health services in its base contract, it is prohibited from billing additional fees for those services. Continuing care retirement communities certified for Medicare or Medicaid, or both, must comply with government reimbursement requirements concerning charges for home health services. The continuing care retirement community shall not bill in excess of its costs. These costs will be determined on non-facility-based Medicare and/or Medicaid standards. Because these continuing care retirement community home health agencies serve only residents of the retirement community, these facilities are not counted in the county need projections.

Home Health Agency Utilization 2010

Agency	Counties Served	Persons Served	Total Visits
Alere Womens & Childrens-Midlands (may serve obstetrical patients only)	Berkeley, Charleston, Colleton, Dorchester, Aiken, Beaufort, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, & Richland	363	1,118
Alere Womens & Childrens-Piedmont (may serve obstetrical patients only)	Anderson, Cherokee, Chesterfield, Greenville, Oconee, Pickens, Spartanburg, York, Abbeville, Allendale, Bamberg, Barnwell, Calhoun, Chester, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Sumter, Orangeburg, Saluda, Union & Williamsburg	410	1,861
Amedysis Home Health of Bluffton *1*	Beaufort, Hampton & Jasper	1,164	24,848
Amedysis Home Health of Camden	Calhoun, Fairfield, Kershaw, Lexington, Newberry, Orangeburg & Richland	1,446	32,979
Amedysis Home Health of Charleston	Berkeley, Charleston & Dorchester	3,844	81,800
Amedysis Home Health of Charleston East	Berkeley, Charleston, Colleton, Dorchester, & Hampton	4,539	90,368
Amedysis Home Health of Clinton	Abbeville, Greenville, Greenwood & Laurens	1,848	41,980
Amedysis Home Health of Conway	Horry	1,463	30,310
Amedysis Home Health Georgetown	Georgetown & Williamsburg	2,013	37,163
Amedysis HH Georgetown East	Georgetown & Williamsburg	193	2,904
Amedisys Home Health Hilton Head	Beaufort & Jasper	1,376	31,099
Amedysis Home Health of Lexington	Calhoun, Edgefield, Lee, Lexington, Newberry, Orangeburg, Richland & Sumter	6,354	141,706
Amedysis Home Health Myrtle Beach	Horry	1,296	26,361
AnMed Health Home Health	Anderson	1,338	26,041
Beaufort-Jasper Home Health Agency	Beaufort & Jasper	202	5,861
Bethea Home Health (may serve retirement community only)	Darlington	27	25,414
CarePro Home Health	Richland & Sumter	292	6,230
Caring Neighbors Home Health	Fairfield	246	6,022
Carolinas Home Health	Darlington, Dillon, Florence & Marlboro	1,307	27,687
Chesterfield Visiting Nurses Services	Chesterfield, Darlington & Marlboro	405	8,766
Clarendon Memorial Home Health	Clarendon	418	6,617

Covenant Place Home Health (may serve retirement community only)	Sumter	6	205
Cypress Club Home Health Agency (may serve retirement community only)	Beaufort	68	3,291
DHEC Region 1 Home Health	Abbeville, Anderson, Edgefield, Greenwood, Laurens, McCormick, Oconee & Saluda	760	16,585
DHEC Region 2 Home Health	Cherokee, Greenville, Pickens, Spartanburg & Union	826	12,652
DHEC Region 3 Home Health	Chester, Fairfield, Lancaster, Lexington, Newberry, Richland & York	1,021	16,144
DHEC Region 4 Home Health	Chesterfield, Clarendon, Darlington, Dillon, Florence, Kershaw, Lee, Marion, Marlboro & Sumter	2,571	43,292
DHEC Region 5 Home Health	Aiken, Allendale, Bamberg, Barnwell, Calhoun & Orangeburg	725	12,814
DHEC Region 6 Home Health	Georgetown, Horry & Williamsburg	508	5,664
DHEC Region 7 Home Health	Berkeley, Charleston & Dorchester	681	14,726
DHEC Region 8 Home Health ***2***	Beaufort, Colleton, Hampton & Jasper	415	6,349
Florence Visiting Nurses Services	Dillon, Florence, Lee & Marion	317	7,152
Franklin C. Fetter Home Health Agency	Charleston	53	991
Gentiva Health Services ***3***	Lexington & Richland	1,520	37,139
Gentiva Health Services - Charleston ***4***	Berkeley, Charleston & Dorchester	562	10,925
Gentiva Health Services - Coastal ***5***	Georgetown, Horry & Williamsburg	1,511	35,361
Gentiva Health Services-Greenville **6** (may only serve patients in Union Co. with initial diag requiring IV therapy and/or home uterine activity monitoring)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg & Union	3,216	80,202
Gentiva Health Services - Upstate ***7***	Cherokee, Chester, Union & York	3,360	71,031
Greenville Hospital System HHA	Greenville & Pickens	1,926	31,326
Health Related Home Care ***8***	Abbeville, Edgefield, Greenwood, Laurens, McCormick & Saluda	1,513	51,384
HomeCare of HospiceCare Piedmont (may only serve terminally ill patients in Saluda County)	Abbeville, Greenwood, Laurens, McCormick & Saluda	17	239
Home Care of Lancaster	Lancaster	1,414	41,027
Home Care of the Regional Medical Ctr	Calhoun & Orangeburg	1,321	24,406
HomeChoice Partners ***9*** (restricted to pediatric patients only)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg, Union, & York	0	0

Home Health Services of Self Regional Healthcare	Abbeville, Greenwood, Laurens, McCormick & Saluda	1,617	51,023
Hospice Care of Low Country Home Health (may serve terminally ill patients only)	Beaufort & Jasper	20	364
Incare Home Health	Georgetown & Horry	1,894	29,734
Interim HealthCare of Greenville	Anderson, Cherokee, Greenville, Oconee, Pickens & Spartanburg	9,637	162,331
Interim HealthCare of Rock Hill	York	1,466	21,189
Intrepid USA Healthcare Services	Allendale, Berkeley, Charleston, Colleton, Dorchester & Georgetown	1,826	35,756
Island Health Care	Beaufort	1,435	28,760
Kershawhealth Home Health	Kershaw	1,103	18,173
Laurel Crest Home Health Agency (may serve retirement community only)	Lexington	0	0
Liberty Home Care - Aiken	Aiken	429	7,265
Liberty Home Care - Bennettsville	Marlboro	334	6,702
Liberty Home Care - Myrtle Beach	Horry	921	13,930
Live Long Wellcare of Brightwater (may serve retirement community only)	Horry	0	0
Live Long Wellcare Litchfield (may serve retirement community only)	Georgetown	7	80
Live Long Wellcare Summit Hills (may serve retirement community only)	Spartanburg	0	0
McLeod Home Health	Darlington, Dillon, Florence, Lee & Marion	2,878	48,699
Methodist Manor Home Health ***10*** (may serve retirement community only)	Florence	0	0
Methodist Oaks Campus Home Health (may serve retirement community only)	Orangeburg	0	0
NHC HomeCare - Aiken	Aiken	595	14,585
NHC HomeCare - Greenwood	Greenwood	279	12,023
NHC HomeCare - Laurens	Greenville & Laurens	1,107	39,240
NHC HomeCare - LowCountry	Berkeley & Dorchester	289	4,417
NHC HomeCare - Midlands	Lexington & Richland	782	13,788
NHC HomeCare - Piedmont	York	524	6,100

Neighbors Care Home Health Agency	Chester	556	12,440
Oconee Memorial Home Health	Anderson, Oconee & Pickens	519	18,776
Palmetto Health HomeCare ***11***	Lexington & Richland	1,495	33,831
Pediatric Home Health ***12*** (restricted to pediatric patients only)	Berkeley, Charleston & Dorchester	710	1,148
Presbyterian Communities of SC ***13*** (may serve retirement communities only)	Berkeley, Dorchester, Florence, Laurens, Lexington & Pickens	0	0
PHC Home Health	Charleston	544	17,292
Roper-St. Francis Home Health Care	Berkeley, Charleston & Dorchester	3,095	58,269
Seabrook Wellness & Home Health Care (may serve retirement community only)	Beaufort	40	2,723
Sea Island Home Health	Charleston & Colleton	113	5,309
Spartanburg Reg Med Ctr Home Health	Spartanburg	2,018	38,686
St. Francis Hospital Home Care	Anderson, Greenville, Pickens & Spartanburg	1,528	25,167
Still Hopes Solutions for Living at Home (may serve retirement community only)	Lexington	97	13,657
Tri-County Home Health Care ***14***	Aiken, Lexington, Richland, Saluda & Sumter	3,873	64,215
Trinity Home Service Home Health	Aiken, Barnwell & Edgefield	848	20,143
Tuomey Home Health (may only serve terminally ill patients in Lee & Clarendon Counties)	Clarendon, Lee & Sumter	1,175	19,109
United Home Care of Lowcountry ***15***	Beaufort	0	0
University Home Health North Augusta	Aiken & Edgefield	1,144	18,590
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Colleton, Hampton & Orangeburg	671	19,755
Wesley Commons Home Health Care (may serve retirement community only)	Greenwood	60	4,097
Westminster Campus Home Health (may serve retirement community only)	York	0	0
		100,484	2,067,406

Home Health Agency Footnotes

1 Name changed, formerly Care One Home Care Services.
2 Licensed amended 2/17/11 to re-add Beaufort and Jasper Counties.
3 Formerly Carolina Home Health Care.
4 Formerly Carolina Home Health Care-Charleston; prior to that was Hospice of Charleston Home Health Agency.
5 Formerly Total Care – Coastal.
6 Formerly Carolina Home Health Care.
7 Formerly Total Care Home Health.
8 CON approved 4/25/12 to serve Edgefield County; appealed.
9 CONs issued 9/22/11 to establish a HHA restricted to pediatric patients only, SC-11-31 through SC-11-35, SC-11-37 through SC-11-40. Licensed 11/14/11.
10 Licensed 2/12/10.
11 De-licensed Bamberg County (served terminally ill patients only) 3/1/11.
12 CONs issued for HHA restricted to pediatric patients only, 12/10/09, SC-09-50, SC-09-51, SC-09-52. Licensed 3/2/10. License amended 11/30/10 to raise the age limit from 14 years and under to 18 years and under.
13 Agency licensed to serve the 6 Presbyterian communities 12/31/11.
14 CON approved for Aiken County; appealed. CON issued 12/1/10, SC-10-35.
15 CON approved for Beaufort County; appealed.

STATE SUMMARY

PROGRAM OF EACH REGION

Regional Need and Narrative
Regional Summary and Program
Inventory of Inpatient Facilities
Inventory of Emergency Facilities and Trauma Centers

This chapter inventories all facilities by either statewide region or inventory region and includes the utilization data of the facilities. All changes that have occurred since the previous Plan are explained by a footnote. The numbers of existing and approved beds are summarized by region. The inventory of beds and facilities was current as of April 30, 2012.

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: STATEWIDE FISCAL YEAR: 2010

1. Statewide Health Facilities: The medical facilities serving the entire state are included in this section. These facilities tend to serve restricted use population groups as well as populations with unique needs. Due to fluctuations in the population groups served by these facilities, these types of facilities will be evaluated on an individual basis should an expansion of services or creation of new services or facilities be requested. This Plan recognizes that the needs of the Department of Mental Health and Department of Disabilities and Special Needs may change as the client population changes, since they cannot refuse any client assigned to them by the courts. Therefore, renovation, replacement, and expansion of component programs should be allowed. Because of special conditions placed on the Department of Juvenile Justice by the courts, their patients/clients must be placed in the appropriate alternative setting. Since these patients/clients are to be placed elsewhere within the State system, the State agency responsible for their care should be allowed to develop these alternative programs by contracting with a private provider, by allowing a private provider to construct a facility for these patients/clients or by the conversion/ construction of their own facilities. Facilities that have a contract with the State to serve such individuals will be approved and counted in the statewide category. Facilities owned and operated by the Department of Mental Health and the Department of Disabilities and Special Needs are exempt from Certificate of Need review except an addition of one or more beds to the total number of beds existing as of July 1, 1988. The Department of Mental Health had 3,720 and the Department of Disabilities and Special Needs had 3,100 beds. The William J. McCord Adolescent Treatment Facility received a CON on 7/16/10 to convert to a specialized hospital restricted primarily to the provision of alcohol and drug abuse treatment for adolescents.

2. All changes affecting the Statewide Health Facilities have been fully annotated in the inventory.

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2010**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
HOSPITALS:								
THE CITADEL INFIRMARY		CHARLESTON	CHARLESTON	ST	38	38		
LIEBER CORRECTIONAL INST INFIRMARY		DORCHESTER	RIDGEVILLE	ST	10	10		
SHRINERS HOSPITAL FOR CHILDREN		GREENVILLE	GREENVILLE	NPA	50	50	1,180	3,607
W.J. BARGE MEMORIAL HOSPITAL		GREENVILLE	GREENVILLE	NPA	79	90		
LEE CORRECTIONAL INSTITUTE INF		LEE	BISHOPVILLE	ST	20	20		
SC VOC REHAB EVALUATION CTR		LEXINGTON	W COLUMBIA	ST	30	30	526	302
GEO CARE OF SOUTH CAROLINA	1	RICHLAND	COLUMBIA	PROP	196	196	242	62,677
MORRIS VILLAGE		RICHLAND	COLUMBIA	ST	11	11		
KIRKLAND CORRECTIONAL INFIRMARY		RICHLAND	COLUMBIA	ST	24	24		
WILLOW LANE INFIRMARY		RICHLAND	COLUMBIA	ST	8	8		
CHILDREN'S HABILITATION CENTER		SPARTANBURG	SPARTANBURG	ST	22	22	299	299
TOTAL					**450**	**461**	**2,247**	**66,885**
MENTAL HOSPITALS:								
PATRICK B HARRIS PSYCHIATRIC		ANDERSON	ANDERSON	ST	200	200	1,142	51,678
G WERBER BRYAN PSYCHIATRIC HOSP		RICHLAND	COLUMBIA	ST	492	492	850	82,400
GILLIAM PSYCHIATRIC HOSPITAL		RICHLAND	COLUMBIA	ST	87	87		
(SC STATE HOSPITAL)	2	RICHLAND	COLUMBIA	ST	(0)	(0)		
WM J MCCORD ADOLESCENT TREAT	3	ORANGEBURG	ORANGEBURG	ST	15	15	113	5,369
WILLIAM S HALL PSYCHIATRIC INSTITUTE		RICHLAND	COLUMBIA	ST	89	89	364	6,353
TOTAL					**883**	**883**	**2,469**	**145,800**
RESIDENTAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:								
DIRECTIONS - WILLIAM S HALL		RICHLAND	COLUMBIA	ST	37	37	37	6,885
TOTAL					**37**	**37**	**37**	**6,885**
DRUG & ALCOHOL INPT TREATMENT:								
PALMETTO CENTER		FLORENCE	FLORENCE	ST	48	48		
HOMESVIEW ALCOHOLIC CTR		GREENVILLE	GREENVILLE	ST	36	36		
(WM J MCCORD ADOLESCENT TREAT)	3	ORANGEBURG	ORANGEBURG	ST	(0)	(0)		
WILLIAM S HALL		RICHLAND	COLUMBIA	ST	19	19	57	5,400
MORRIS VILLAGE		RICHLAND	COLUMBIA	ST	163	163	1,572	40,796
TOTAL					**266**	**266**	**1,629**	**46,196**
LONG TERM FACILITIES:								
RICHARD M CAMPBELL VA NURS HOME		ANDERSON	ANDERSON	ST	220	220	115	76,104
PRESTON HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	8	8	16	1,786
FRASER HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	14	14	51	3,954
BISHOP GADSDEN EPISCOPAL		CHARLESTON	CHARLESTON	NPA	9	9	16	2,854
THE FRANKE HEALTH CARE CTR	4	CHARLESTON	MT PLEASANT	NPA	20	(0)	70	6,623
VETERANS VICTORY HOUSE		COLLETON	WALTERBORO	ST	220	220	181	68,030

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2010**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
BETHEA BAPTIST HOME		DARLINGTON	DARLINGTON	NPA	52	52	43	16,472
PRESBYTERIAN HOME SUMMERVILLE		DORCHESTER	SUMMERVILLE	NPA	0	0		
PRESBYTERIAN HOME FLORENCE	5	FLORENCE	FLORENCE	NPA	26	26	20	11,561
METHODIST MANOR HEALTHCARE CTR		FLORENCE	FLORENCE	NPA	32	32	15	9,870
LAKES AT LITCHFIELD SKILLED NSG CTR		GEORGETOWN	PAWLEYS ISLAND	PROP	7	7	46	1,753
(ROLLING GREEN VILLAGE HC FACILITY)	6	GREENVILLE	GREENVILLE	NPA	(0)	(0)	68	11,833
(LINVILLE COURTS CASCADES VERDAE)	7	GREENVILLE	GREENVILLE	PROP	(0)	(0)		
(ARBORETUM WOODLANDS)	8	GREENVILLE	GREENVILLE	PROP	(13)	(13)	15	546
PRESBYTERIAN HOME OF SC CLINTON		LAURENS	CLINTON	NPA	48	48	39	17,841
MARTHA FRANK BAPTIST HOME		LAURENS	LAURENS	NPA	7	7	11	2,413
(SC EPISCOPAL HOME STILL HOPES)	9	LEXINGTON	W COLUMBIA	NPA	(0)	(0)	31	12,498
LAUREL CREST RETIREMENT CENTER		LEXINGTON	W COLUMBIA	NPA	12	12	7	3,790
PRESBYTERIAN HOME OF COLUMBIA		LEXINGTON	W COLUMBIA	NPA	44	0	50	14,427
CLEMSON AREA RETIREMENT CENTER		PICKENS	CLEMSON	PROP	22	22	20	5,551
PRESBYTERIAN HOME OF SC - FOOTHILLS		PICKENS	EASLEY	NPA	18	18	10	6,570
CM TUCKER JR NURS CTR-FEWELL/STONE		RICHLAND	COLUMBIA	ST	252	252	69	77,337
CM TUCKER JR NURS CTR-RODDEY		RICHLAND	COLUMBIA	ST	308	308	36	67,273
WILDEWOOD DOWNS NSG & REHAB		RICHLAND	COLUMBIA	PROP	8	8	11	630
WJB DORN VETERANS NURSING		RICHLAND	COLUMBIA	FED	62	150		
EMERITUS AT SKYLYN HEALTH CARE CTR		SPARTANBURG	SPARTANBURG	PROP	11	11	18	3,117
SUMMIT HILLS NURSING CENTER		SPARTANBURG	SPARTANBURG	PROP	6	6	24	1,296
COVENANT PLACE NURS CTR	10	SUMTER	SUMTER	NPA	16	16	25	1,338
TOTAL					**1,422**	**1,446**	**1,007**	**425,467**

STATEWIDE

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. Formerly Columbia Regional Care Center.
2. Facility closed effective 2/29/12.
3. CON issued 7/16/10 to convert the McCord Adolescent Treatment Facility to a specialized hospital restricted primarily to the provision of alcohol and drug abuse treatment for adolescents.
4. CON issued 12/20/11 to convert 20 institutional nursing home beds to community beds, for a total of 44 community beds, SC-11-54.
5. Exemption issued 4/16/10 for the permanent de-licensure of 18 beds, for a total of 26 licensed nursing home beds. Licensed for 26 beds 6/24/10.
6. CON issued 7/28/11 to convert 34 existing institutional nursing home beds to community beds and add 30 new community beds for a total of 74 community nursing home beds not participating in the Medicaid program, SC-11-28. The 34 institutional beds were converted on 10/31/11.
7. CON issued 7/1/11 to convert the 22 institutional beds to nursing home beds not participating in the Medicaid program, for a total of 44 community nursing home beds, SC-11-23. Licensed for 44 community nursing home beds 7/18/11.
8. CON issued 6/10/10 to convert the 13 institutional beds to community beds, SC-10-17. Licensed for 30 community beds effective 6/10/10.
9. CON issued 12/28/11 to convert 42 institutional nursing home beds to community beds, for a total of 62 community and 0 institutional beds, SC-11-53.
10. CON issued 1/31/11 to convert 28 institutional nursing home beds to community beds that do not participate in the Medicaid program, for a total of 16 institutional and 28 community beds, SC-11-03. Licensed for 28 community and 16 institutional beds 6/21/11.

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: I

FISCAL YEAR: 2010

1. Unusual Characteristics: There are no unusual characteristics such as military bases with associated dependents, nor barriers to transportation in this region.

2. General Hospitals: W.J. Barge Hospital is a privately owned Educational Institutional Infirmary.

3. Nursing Homes: There is a need for additional nursing home beds in this area.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter IV for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter VI for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter V for discussion and calculation of needs.

REGION: I **INPATIENT INVENTORY** **FISCAL YEAR 2010**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
ANMED HEALTH MEDICAL CENTER		ANDERSON	ANDERSON	NPA	423	423	14,917	75,310	423	48.8%
ANMED HEALTH WOMEN'S & CHILDREN'S HOSPITAL		ANDERSON	ANDERSON	NPA	72	72	3,359	7,593	72	28.9%
ANDERSON COUNTY		TOTAL			495	495	18,276	82,903	495	45.9%
UPSTATE CAROLINA MEDICAL CENTER		CHEROKEE	GAFFNEY	PROP	125	125	3,506	14,380	125	31.5%
CHEROKEE COUNTY		TOTAL			125	125	3,506	14,380	125	31.5%
GREENVILLE MEMORIAL MEDICAL CENTER		GREENVILLE	GREENVILLE	NPA	746	746	32,786	167,316	746	61.4%
GREER MEMORIAL HOSPITAL		GREENVILLE	GREER	NPA	82	82	3,522	11,959	82	40.0%
HILLCREST MEMORIAL HOSPITAL		GREENVILLE	SIMPSONVILLE	NPA	43	43	1,874	6,859	43	43.7%
PATEWOOD MEMORIAL HOSPITAL		GREENVILLE	GREENVILLE	NPA	72	72	1,255	2,714	72	10.3%
SAINT FRANCIS - DOWNTOWN	1	GREENVILLE	GREENVILLE	NPA	226	226	12,250	54,063	226	65.5%
(SAINT FRANCIS MILLENNIUM)	1	GREENVILLE	GREENVILLE	NPA		(0)				
SAINT FRANCIS - EASTSIDE		GREENVILLE	GREENVILLE	NPA	93	93	7,075	17,165	93	50.6%
GREENVILLE COUNTY		TOTAL			1,262	1,262	58,762	260,076	1,262	56.5%
OCONEE MEDICAL CENTER	2	OCONEE	SENECA	NPA	169	169	7,170	28,890	163.5	48.4%
OCONEE COUNTY					169	169	7,170	28,890	163.5	48.4%
BAPTIST EASLEY HOSPITAL		PICKENS	EASLEY	NPA	109	109	4,563	18,905	109	47.5%
CANNON MEMORIAL HOSPITAL		PICKENS	PICKENS	NPA	55	55	1,000	3,928	55	19.6%
PICKENS COUNTY		TOTAL			164	164	5,563	22,833	164	38.1%
MARY BLACK MEMORIAL HOSPITAL	3	SPARTANBURG	SPARTANBURG	PROP	176	174	6,510	27,172	176	42.3%
SPARTANBURG REGIONAL MEDICAL CENTER		SPARTANBURG	SPARTANBURG	CO	484	484	26,604	131,165	484	74.2%
VILLAGE HOSPITAL		SPARTANBURG	GREER	CO	48	48	1,541	5,367	48	30.6%
SPARTANBURG COUNTY		TOTAL			708	706	34,655	163,704	708	63.3%
WALLACE THOMSON HOSPITAL		UNION	UNION	DIST	143	143	2,429	9,307	143	17.8%
UNION COUNTY		TOTAL			143	143	2,429	9,307	143	17.8%
TOTAL					3,066	3,064	130,361	582,093	3,060.5	52.1%
LONG TERM ACUTE HOSPITALS:										
NORTH GREENVILLE HOSP LONG TERM ACUTE		GREENVILLE	TRAVELERS RES	NPA	45	45	313	8,930	45	54.4%
REGENCY HOSPITAL OF GREENVILLE	4	GREENVILLE	GREENVILLE	NPA	32	32			32	0.0%
SPARTANBURG HOSPITAL FOR RESTORATIVE CARE		SPARTANBURG	SPARTANBURG	CO	97	97	391	13,097	97	37.0%
TOTAL					129	129	704	22,027	174	34.7%
MENTAL FACILITIES:										
ANMED HEALTH MEDICAL CENTER		ANDERSON	ANDERSON	NPA	38	38	1,076	6,243	38	45.0%
ANDERSON COUNTY		TOTAL			38	38	1,076	6,243	38	45.0%
CAROLINA CENTER FOR BEHAVIORAL HEALTH	5	GREENVILLE	GREENVILLE	PROP	99	104	2,263	25,328	87.1	79.7%
SPRINGBROOK BEHAVIORAL HEALTHCARE	6	GREENVILLE	TRAVELERS RES	PROP	28	37	398	5,025	20	68.8%
GREENVILLE MEMORIAL MEDICAL CENTER		GREENVILLE	GREENVILLE	NPA	46	46	1,376	14,090	46	83.9%
GREENVILLE COUNTY		TOTAL			173	187	4,037	44,443	153.1	79.5%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	15	15	352	3,742	15	68.3%
SPARTANBURG REGIONAL MEDICAL CENTER		SPARTANBURG	SPARTANBURG	CO	56	56	575	5,135	56	25.1%
SPARTANBURG COUNTY		TOTAL			71	71	927	8,877	71	34.3%
TOTAL					282	296	6,040	59,563	262.1	62.3%

REGION: I **INPATIENT INVENTORY** **FISCAL YEAR 2010**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
EXCALIBUR YOUTH SERVICES		GREENVILLE	SIMPSONVILLE	PROP	60	60	66	11,925	60	54.5%
GENERATIONS RESIDENTIAL PROGRAM	7	GREENVILLE	GREENVILLE	PROP	30	30				
MARSHALL I. PICKENS CHILDREN'S PROGRAM		GREENVILLE	GREENVILLE	NPA	22	22	28	7,741	22	96.4%
SPRINGBROOK BEHAVIORAL HEALTHCARE		GREENVILLE	TRAVELERS RES	PROP	68	68	90	20,281	68	81.7%
AVALONIA GROUP HOME		PICKENS	PICKENS	PROP	55	55	73	13,068	55	65.1%
TOTAL					235	235	257	53,015	205	70.9%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
CAROLINA CENTER FOR BEHAVIORAL HEALTH	5	GREENVILLE	GREENVILLE	PROP	13	21	704	5,660	13	119.3%
TOTAL					13	21	704	5,660	13	119.3%
REHABILITATION FACILITIES:										
ANMED HEALTH REHABILITATION HOSPITAL	8	ANDERSON	ANDERSON	PROP	55	55	1,114	14,628	43.5	92.1%
ANDERSON COUNTY		TOTAL			55	55	1,114	14,628	43.5	92.1%
GREENVILLE MEMORIAL MEDICAL CENTER		GREENVILLE	GREENVILLE	NPA	53	53	659	11,288	53	58.4%
SAINT FRANCIS HOSPITAL - DOWNTOWN		GREENVILLE	GREENVILLE	NPA	19	19	443	6,016	19	86.7%
GREENVILLE COUNTY		TOTAL			72	72	1,102	17,304	72	65.8%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	18	18	296	3,857	18	58.7%
SPARTANBURG REHABILITATION INSTITUTE	9	SPARTANBURG	SPARTANBURG	PROP		28				
SPARTANBURG COUNTY		TOTAL			18	46	296	3,857	18	58.7%
TOTAL					127	173	2,216	31,932	115.5	75.7%
INPATIENT HOSPICE FACILITIES:										
CALLIE & JOHN RAINEY / HOSPICE OF THE UPSTATE		ANDERSON	ANDERSON	NPA	32	32	667	8,739	32	74.8%
MCCALL HOSPICE HOUSE OF GREENVILLE		GREENVILLE	SIMPSONVILLE	NPA	30	30	681	8,257	30	75.4%
OCONEE MEMORIAL HOSPICE FOOTHILLS		OCONEE	SENECA	NPA	15	15	264	3,737	15	68.3%
HOSPICE HOUSE OF CAROLINA FOOTHILLS		SPARTANBURG	LANDRUM	NPA	12	12	195	2,226	12	50.8%
SPARTANBURG REG HEALTHCARE HOSPICE		SPARTANBURG	SPARTANBURG	NPA	15	15	534	4,645	15	84.8%
TOTAL					104	104	2,341	27,604	104	72.7%
LONG TERM CARE FACILITIES:										
ELLENBURG NURSING CENTER		ANDERSON	ANDERSON	PROP	181	181	255	62,788	181	95.0%
EMERITUS AT ANDERSON PLACE HEALTH CARE CENTER	10	ANDERSON	ANDERSON	PROP	44	44	31	10,244	44	63.8%
EXALTED HEALTH & REHAB IVA		ANDERSON	IVA	PROP	60	60	132	21,254	60	97.1%
FELLOWSHIP HEALTH & REHAB ANDERSON		ANDERSON	ANDERSON	PROP	88	88	170	31,054	88	96.7%
GARDENS AT TOWN CREEK	11	ANDERSON	PENDLETON	PROP	0	60				
HOSANNA HEALTH & REHAB PIEDMONT		ANDERSON	ANDERSON	PROP	88	88	227	31,000	88	96.5%
NHC HEALTHCARE ANDERSON		ANDERSON	ANDERSON	PROP	290	290	537	103,451	290	97.7%
ANDERSON COUNTY		TOTAL			751	811	1,352	259,791	751	94.8%
BROOKVIEW HEALTHCARE CENTER		CHEROKEE	GAFFNEY	PROP	132	132	180	47,038	132	97.4%
CHEROKEE COUNTY LONG TERM CARE FACILITY		CHEROKEE	GAFFNEY	CO	111	111	269	35,793	111	88.1%
CHEROKEE COUNTY		TOTAL			243	243	449	82,831	243	93.1%
ALPHA HEALTH & REHAB GREER	12	GREENVILLE	GREER	PROP	132	133	609	44,895	132	93.2%
ARBORETUM OF WOODLANDS AT FURMAN	13	GREENVILLE	GREENVILLE	PROP	30	30	211	7,746	30	70.7%
(ARBORETUM OF WOODLANDS AT FURMAN)		GREENVILLE	GREENVILLE	PROP	(0)	(0)				
COTTAGES AT BRUSHY CREEK		GREENVILLE	GREENVILLE	NPA	144	144	470	50,351	144	95.8%
DAYSPRING HEALTH & REHAB SIMPSONVILLE	12	GREENVILLE	SIMPSONVILLE	PROP	42	120	35	14,060	42	91.7%
DIAMOND HEALTH & REHAB SIMPSONVILLE		GREENVILLE	SIMPSONVILLE	PROP	132	132	229	46,169	132	95.8%
EMERITUS AT GREENVILLE	14	GREENVILLE	GREENVILLE	PROP	45	45	226	13,073	45	79.6%
FOUNTAIN INN NURSING HOME		GREENVILLE	FOUNTAIN INN	PROP	60	60	83	20,406	60	93.2%
GLORIFIED HEALTH & REHAB GREENVILLE		GREENVILLE	GREENVILLE	PROP	132	132	315	46,386	132	96.3%
GREENVILLE MEMORIAL MED CTR SUBACUTE		GREENVILLE	GREENVILLE	NPA	15	15	311	4,623	15	84.4%
HOPE HEALTH & REHAB MARIETTA		GREENVILLE	MARIETTA	NPA	44	44	29	15,657	44	97.5%
LAUREL BAYE HEALTHCARE OF GREENVILLE		GREENVILLE	GREENVILLE	PROP	132	132	198	41,667	132	86.5%

REGION: I **INPATIENT INVENTORY** **FISCAL YEAR 2010**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
LINVILLE COURTS AT CASCADES VERDAE	15	GREENVILLE	GREENVILLE	PROP	44	44				
(LINVILLE COURTS AT CASCADES VERDE)		GREENVILLE	GREENVILLE	PROP	(0)	(0)				
MAGNOLIA MANOR - GREENVILLE		GREENVILLE	GREENVILLE	PROP	99	99	51	34,000	99	94.1%
MAGNOLIA PLACE - GREENVILLE		GREENVILLE	GREENVILLE	PROP	120	120	140	41,577	120	94.9%
NHC HEALTHCARE GREENVILLE		GREENVILLE	GREER	PROP	176	176	504	62,218	176	96.9%
NHC HEALTHCARE MAULDIN		GREENVILLE	MAULDIN	PROP	180	180	442	62,655	180	95.4%
OAKMONT EAST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	132	132	299	43,555	132	90.4%
OAKMONT WEST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	125	125	343	42,019	124	92.8%
OMEGA HEALTH & REHAB GREENVILLE	12	GREENVILLE	GREENVILLE	PROP	79	0	73	27,109	79	94.0%
ROLLING GREEN VILLAGE HEALTH CARE FACILITY	16	GREENVILLE	GREENVILLE	NPA	44	74	23	3,351	10	91.8%
(ROLLING GREEN VILLAGE HEALTH CARE FACILITY)		GREENVILLE	GREENVILLE	NPA	(0)	(0)				
GREENVILLE COUNTY		TOTAL			1,907	1,937	4,591	621,517	1,828	92.9%
LILA DOYLE NURSING CARE FACILITY		OCONEE	SENECA	CO	120	120	516	27,280	120	62.3%
SENECA HEALTH AND REHABILITATION CENTER		OCONEE	SENECA	PROP	132	132	446	61,312	132	
OCONEE COUNTY		TOTAL			252	252	962	88,592	252	96.3%
CAPSTONE HEALTH & REHAB EASLEY	17	PICKENS	EASLEY	PROP	66	60	82	23,105	66	95.9%
CLEMSON AREA RETIREMENT CENTER		PICKENS	CLEMSON	PROP	30	30	23	8,462	30	77.3%
(CLEMSON AREA RETIREMENT CENTER)		PICKENS	CLEMSON	PROP	(22)	(22)				
EMERITUS COUNTRYSIDE HEALTHCARE CENTER		PICKENS	EASLEY	PROP	44	44	58	15,781	44	98.3%
HERITAGE HEALTHCARE OF PICKENS		PICKENS	SIX MILE	PROP	44	44	67	15,149	44	94.3%
MAJESTY HEALTH & REHAB EASLEY		PICKENS	EASLEY	PROP	103	103	179	35,973	103	95.7%
MANNA HEALTH & REHAB PICKENS	17	PICKENS	PICKENS	PROP	80	130	145	27,993	80	95.9%
PRESBYTERIAN HOME - FOOTHILLS	18	PICKENS	EASLEY	PROP	26	26	11	3,746	26	39.5%
(PRESBYTERIAN HOME - FOOTHILLS)		PICKENS	EASLEY	PROP	(18)	(18)				
REDEEMER HEALTH & REHAB PICKENS	17	PICKENS	PICKENS	PROP	44	(0)	51	15,424	44	96.0%
PICKENS COUNTY		TOTAL			437	437	616	145,633	437	91.3%
CAMP CARE		SPARTANBURG	INMAN	PROP	88	88	118	31,010	88	96.5%
EMERITUS AT SKYLYN HEALTH CARE CENTER		SPARTANBURG	SPARTANBURG	PROP	33	33	35	9,816	35	76.8%
(EMERITUS AT SKYLYN HEALTH CARE CENTER)		SPARTANBURG	SPARTANBURG	PROP	(11)	(11)				
GOLDEN AGE - INMAN		SPARTANBURG	INMAN	PROP	44	44	42	14,278	44	88.9%
INMAN HEALTHCARE		SPARTANBURG	INMAN	PROP	40	40	26	13,885	40	95.1%
MAGNOLIA MANOR - INMAN		SPARTANBURG	INMAN	PROP	176	176	182	62,013	176	96.5%
MAGNOLIA MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	95	95	120	32,236	95	93.0%
MAGNOLIA PLACE - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	88	88	192	30,487	88	94.9%
MOUNTAINVIEW NURSING HOME		SPARTANBURG	SPARTANBURG	CO	132	132	40	47,581	132	98.8%
ROSECREST REHABILITATION & HEALTHCARE		SPARTANBURG	INMAN	NPA	75	75	253	22,257	75	81.3%
SPARTANBURG HOSP RESTORATIVE CARE SNF		SPARTANBURG	SPARTANBURG	CO	25	25	430	5,473	25	60.0%
SPARTANBURG REHABILITATION INSTITUTE	9	SPARTANBURG	SPARTANBURG	PROP		12				
SUMMIT HILLS NURSING CENTER		SPARTANBURG	SPARTANBURG	PROP	27	27	121	7,318	27	74.3%
(SUMMIT HILLS NURSING CENTER)		SPARTANBURG	SPARTANBURG	PROP	(6)	(6)				
VALLEY FALLS TERRACE		SPARTANBURG	SPARTANBURG	PROP	88	88	45	30,725	88	95.7%
WHITE OAK ESTATES		SPARTANBURG	SPARTANBURG	PROP	88	88	135	31,472	88	98.0%
WHITE OAK MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	192	192	176	66,418	192	94.8%
WOODRUFF MANOR		SPARTANBURG	WOODRUFF	PROP	88	88	21	31,858	88	99.2%
SPARTANBURG COUNTY		TOTAL			1,279	1,291	1,936	436,827	1,281	93.4%
ELLEN SAGAR NURSING HOME		UNION	UNION	CO	113	113	196	40,568	113	98.4%
OAKMONT OF UNION		UNION	UNION	PROP	88	88	313	30,124	88	93.8%
UNION COUNTY		TOTAL			201	201	509	70,692	201	96.4%
TOTAL					5,070	5,172	10,415	1,705,883	4,993	93.6%

FOOTNOTES 2012-2013 PLAN

REGION I

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON issued 6/12/09 to construct a new 52 bed hospital (St. Francis millennium) through the transfer of the 50 bed need generated by St. Francis Downtown and the transfer of 2 beds from St. Francis Downtown, for a total of 224 beds at St. Francis Downtown, SC-09-28. CON voided 8/1/11, St. Francis Downtown remains licensed for 226 beds.
2. CON issued for a 9 bed addition 9/14/06, SC-06-55. Licensed for 169 beds, 4/15/10. Name changed from Oconee Memorial Hospital.
3. Notified the Department on 4/16/12 that they intended to de-license 2 general acute beds for a total of 174 general acute, 15 psychiatric, and 18 rehabilitation beds.
4. Facility failed to provide utilization data for 2010.
5. CON issued 8/10/09 to add 23 psych beds for a total of 99 psych and 13 substance abuse beds, SC-09-37. Licensed 8 additional psych beds for a total of 84, 2/16/10. Licensed for 99 psych beds 9/23/10. CON issued 4/26/12 to add 5 psych beds for a total of 104 and 8 substance abuse beds for a total of 21, SC-12-10.
6. CON issued 8/10/09 to add 17 psych beds for a total of 37 psych and 68 RTF beds, SC-09-38. Licensed 8 additional beds for a total of 28, 9/20/11.
7. Exemption to convert from a High Maintenance Group Home to an RTF. Licensed for 30 RTF beds on 8/25/11.
8. CON to convert 3 nursing home beds to rehab beds, for a total of 40 rehab beds 5/14/09, SC-09-25. CON issued for 5 additional rehab beds, for a total of 45, 7/8/09, SC-09-35. Licensed for 40 rehab beds 7/1/09; licensed for 45 beds 4/22/10. CON issued 9/22/11 to add 10 rehab beds for a total of 55, SC-11-42. Licensed for 55 beds 1/1/12.
9. CON approved for a facility with 28 rehab and 12 nursing home beds; appealed.
10. Formerly Anderson Place.
11. CON issued 9/9/10 to construct a 60 bed nursing home that does not participate in the Medicaid program, SC-10-29.
12. CON issued 11/28/11 to construct a 120 bed nursing facility to consolidate the existing 42 beds at Dayspring Health & Rehab, and 78 of the 79 existing beds at Omega Health & Rehab of Greenville, SC-11-51. The remaining bed from Omega Health & Rehab was added to Alpha Health & Rehab of Greer, for a total of 133 beds.
13. CON issued 6/10/10 to convert the 13 institutional beds to community beds, SC-10-17. Licensed for 30 community beds, 6/10/10.
14. Formerly Brighton Gardens.
15. CON issued 5/12/09 to convert 22 institutional beds to nursing home beds not participating in the Medicaid program. The licensed was amended 5/12/09 to reflect the change to 22 institutional and 22 nursing home beds not participating in the Medicaid program. Name changed 8/8/09. CON issued 7/1/11 to convert the 22 institutional beds to nursing home beds not participating in the Medicaid program, for a total of 44 community nursing home beds,

SC-11-23. Licensed for 44 community nursing home beds 7/18/11. Facility failed to provide utilization data for 2010.

16. CON issued 7/28/11 to convert 34 existing institutional nursing home beds to community beds and add 30 new community beds for a total of 74 community nursing home beds not participating in the Medicaid program, SC-11-28. The 34 institutional beds were converted on 10/31/11 for a total of 44 community beds.
17. CON issued 10/19/11 to construct a 50 bed addition at Manna Health & Rehab of Pickens by consolidating 44 beds from Redeemer Health & Rehab of Pickens and 6 beds from Capstone Health & Rehab of Easley, SC-11-47. The final result will be 130 beds at Manna, 60 beds at Capstone, and Redeemer will close.
18. CON issued 1/14/10 to construct 26 nursing home beds for a total of 44, with 18 restricted to residents of the retirement community, SC-10-04. The facility was licensed for 18 institutional nursing home beds and 26 community nursing home beds 8/2/11.

INVENTORY OF EMERGENCY FACILITIES

CATEGORY	NAME OF FACILITY	2009 ER VISITS	2010 ER VISITS
REGION I:	EMERGENCY FACILITIES		
II	ANMED HEALTH MEDICAL CENTER	85,695	59,549
III	UPSTATE CAROLINA MEDICAL CENTER	31,778	33,497
II	GREENVILLE MEMORIAL HOSPITAL	87,710	87,006
I	GREER MEMORIAL/ALLEN BENNETT	31,143	31,478
II	HILLCREST HOSPITAL	28,706	29,134
III	NORTH GREENVILLE LTACH	18,950	17,265
II	SAINT FRANCIS - DOWNTOWN	41,026	42,327
II	SAINT FRANCIS - EASTSIDE	32,200	29,644
III	OCONEE MEMORIAL HOSPITAL	39,162	36,603
III	PALMETTO BAPTIST MED CTR-EASLEY	42,289	42,979
III	CANNON MEMORIAL HOSPITAL	18,007	17,867
III	MARY BLACK MEMORIAL HOSPITAL	27,838	28,650
I	SPARTANBURG REGIONAL MED CTR	106,505	102,699
III	WALLACE THOMSON HOSPITAL	18,955	18,210
		609,964	560,519

REGION I:	TRAUMA CENTERS	
II	ANMED HEALTH MEDICAL CENTER	
I	GREENVILLE MEMORIAL HOSPITAL	
III	GREER MEMORIAL	
I	SPARTANBURG REGIONAL MED CTR	

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: II

FISCAL YEAR: 2010

1. Unusual Characteristics: This region has a military base at Fort Jackson with a military hospital to provide health care services for the active duty and dependents residing in this region. A 457 bed Veterans Administration Hospital and 120 bed Veterans Nursing Home is located in Columbia. There are no barriers to transportation. Most State owned psychiatric facilities and the largest substance abuse treatment facility are located in this region.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only. All facilities are conforming. After a review of patient origin information, the population used to calculate Richland County hospital bed need is 91.1% of the Richland County population plus 41.2% of the population of Lexington County. For Lexington County, 58.8% of the Lexington County population plus 8.9% of the Richland County population is used. A separate bed need is indicated for each county.

3. Nursing Homes: There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter IV for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter VI for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter V for discussion and calculation of needs.

REGION: II **INPATIENT INVENTORY** **FISCAL YEAR 2010**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
ABBEVILLE AREA MEDICAL CENTER		ABBEVILLE	ABBEVILLE	CO	25	25	803	2,894	25	31.7%
ABBEVILLE COUNTY		TOTAL			25	25	803	2,894	25	31.7%
CHESTER REGIONAL MEDICAL CENTER		CHESTER	CHESTER	DIST	82	82	1,830	5,722	82	19.1%
CHESTER COUNTY		TOTAL			82	82	1,830	5,722	82	19.1%
EDGEFIELD COUNTY HOSPITAL		EDGEFIELD	EDGEFIELD	CO	25	25	332	1,218	25	13.3%
EDGEFIELD COUNTY		TOTAL			25	25	332	1,218	25	13.3%
FAIRFIELD MEMORIAL HOSPITAL		FAIRFIELD	WINNSBORO	NPA	25	25	591	3,016	25	33.1%
FAIRFIELD COUNTY		TOTAL			25	25	591	3,016	25	33.1%
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	354	354	12,636	51,363	354	39.8%
GREENWOOD COUNTY		TOTAL			354	354	12,636	51,363	354	39.8%
KERSHAW HEALTH		KERSHAW	CAMDEN	CO	121	121	5,416	23,913	121	54.1%
KERSHAW COUNTY		TOTAL			121	121	5,416	23,913	121	54.1%
SPRINGS MEMORIAL HOSPITAL	1	LANCASTER	LANCASTER	NPA	199	199	7,355	31,849	199	43.8%
LANCASTER COUNTY		TOTAL			199	199	7,355	31,849	199	43.8%
LAURENS COUNTY HOSPITAL		LAURENS	LAURENS	DIST	76	76	2,805	11,899	76	42.9%
LAURENS COUNTY		TOTAL			76	76	2,805	11,899	76	42.9%
LEXINGTON MEDICAL CENTER	2	LEXINGTON	WEST COLUMBIA	CO	414	414	18,729	90,093	387.1	63.8%
LEXINGTON COUNTY		TOTAL			414	414	18,729	90,093	387.1	63.8%
NEWBERRY COUNTY MEMORIAL HOSPITAL		NEWBERRY	NEWBERRY	CO	90	90	2,077	8,109	90	24.7%
NEWBERRY COUNTY		TOTAL			90	90	2,077	8,109	90	24.7%
PALMETTO HEALTH BAPTIST	3	RICHLAND	COLUMBIA	NPA	363	287	14,851	69,150	363	52.2%
PALMETTO HEALTH PARKRIDGE	3	RICHLAND	COLUMBIA	NPA		76				
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	NPA	579	579	28,751	170,716	579	80.8%
PROVIDENCE HOSPITAL		RICHLAND	COLUMBIA	PROP	258	258	9,799	52,209	258	55.4%
PROVIDENCE HOSPITAL NORTHEAST	4	RICHLAND	COLUMBIA	PROP	56	84	3,308	10,556	46	62.9%
(MONCRIEF ARMY HOSPITAL)	5	RICHLAND	COLUMBIA	FED		(63)				
(W J B DORN VA HOSPITAL)	5	RICHLAND	COLUMBIA	FED		(400)				
RICHLAND COUNTY		TOTAL			1,256	1,284	56,709	302,631	1,246	66.5%
CAROLINAS MEDICAL CENTER - FORT MILL	6	YORK	FORT MILL	NPA		50				
PIEDMONT MEDICAL CENTER		YORK	ROCK HILL	PROP	268	268	13,274	56,723	268	58.0%
YORK COUNTY		TOTAL			268	318	13,274	56,723	268	58.0%
TOTAL					2,935	3,013	122,557	589,430	2,898.1	55.7%
LONG TERM ACUTE HOSPITALS:										
INTERMEDICAL HOSPITAL OF SOUTH CAROLINA		RICHLAND	COLUMBIA	NPA	35	35	273	7,861	35	61.5%
TOTAL					35	35	273	7,861	35	61.5%
MENTAL FACILITIES:										
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	36	36	656	5,046	36	38.4%
GREENWOOD COUNTY		TOTAL			36	36	656	5,046	36	38.4%
THREE RIVERS BEHAVIORAL HEALTH		LEXINGTON	WEST COLUMBIA	PROP	81	81	1,361	24,248	81	82.0%
LEXINGTON COUNTY		TOTAL			81	81	1,361	24,248	81	82.0%
PALMETTO HEALTH BAPTIST		RICHLAND	COLUMBIA	NPA	94	94	1,886	22,322	94	65.1%
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	60	60	821	5,552	60	25.4%
(MONCRIEF ARMY HOSPITAL)	5	RICHLAND	COLUMBIA	FED		(20)				

REGION: II **INPATIENT INVENTORY** **FISCAL YEAR 2010**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
(W J B DORN VA)	6	RICHLAND	COLUMBIA	FED		(60)				
RICHLAND COUNTY		TOTAL			154	154	2,707	27,874	154	49.6%
PIEDMONT MEDICAL CENTER		YORK	ROCK HILL	PROP	20	20	565	4,628	20	63.4%
YORK COUNTY		TOTAL			20	20	565	4,628	20	63.4%
TOTAL					291	291	5,289	61,796	291	58.0%
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
THREE RIVERS RESIDENTIAL TREATMENT - MIDLANDS		LEXINGTON	WEST COLUMBIA	PROP	59	59	109	18,703	59	86.8%
THREE RIVERS BEHAVIORAL HEALTH RTC		LEXINGTON	WEST COLUMBIA	PROP	20	20	21	5,626	20	77.1%
CAROLINA CHILDREN'S HOME	7	RICHLAND	COLUMBIA	NPA	30	30	26	5,265	20	72.1%
NEW HOPE CAROLINAS		YORK	ROCK HILL	PROP	150	150	274	48,148	150	87.9%
YORK PLACE EPISCOPAL HOME		YORK	YORK	PROP	40	40	52	9,885	40	67.7%
TOTAL					299	299	482	87,627	289	83.1%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
SPRINGS MEMORIAL HOSPITAL	1	LANCASTER	LANCASTER	NPA	18	18	0	0	18	0.0%
THREE RIVERS BEHAVIORAL HEALTH		LEXINGTON	WEST COLUMBIA	PROP	17	17	547	3,928	17	63.3%
PALMETTO HEALTH BAPTIST		RICHLAND	COLUMBIA	CO	10	10	0	0	10	0.0%
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	10	10	300	3,419	10	93.7%
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	24	24	0	0	24	0.0%
TOTAL					79	79	847	7,347	79	25.4%
REHABILITATION FACILITIES:										
GREENWOOD REGIONAL REHAB HOSPITAL	8	GREENWOOD	GREENWOOD	NPA	34	42	780	10,446	34	84.2%
GREENWOOD COUNTY		TOTAL			34	42	780	10,446	34	84.2%
HEALTHSOUTH REHAB HOSPITAL COLUMBIA		RICHLAND	COLUMBIA	PROP	96	96	1,413	20,663	96	59.0%
RICHLAND COUNTY		TOTAL			96	96	1,413	20,663	96	59.0%
HEALTHSOUTH REHAB HOSPITAL ROCK HILL	9	YORK	ROCK HILL	PROP	50	50	1,000	13,389	45.4	80.8%
YORK COUNTY		TOTAL			50	50	1,000	13,389	45.4	80.8%
TOTAL					180	188	3,193	44,498	175.4	69.5%
INPATIENT HOSPICE FACILITIES:										
HOSPICE HOUSE OF HOSPICECARE PIEDMONT		GREENWOOD	GREENWOOD	NPA	15	15	296	2,651	15	48.4%
HOSPICE OF LAURENS CO INPT HOSPICE HOUSE		LAURENS	CLINTON	PROP	12	12	109	1,611	12	36.8%
AGAPE HOSPICE HOUSE OF THE MIDLANDS	10	RICHLAND	COLUMBIA	PROP	12	12				
(ASCENSION HOUSE)	11	RICHLAND	IRMO	PROP	(0)	(0)				
HOSPICE AND COMMUNITY CARE		YORK	ROCK HILL	NPA	16	16	225	1,937	16	33.2%
TOTAL					55	55	630	6,199	43	39.5%
LONG TERM CARE FACILITIES:										
ABBEVILLE NURSING HOME		ABBEVILLE	ABBEVILLE	PROP	94	94	59	32,429	94	94.5%
CARLISLE NURSING CENTER		ABBEVILLE	DUE WEST	NPA	22	22	20	4,989	22	62.1%
ABBEVILLE COUNTY		TOTAL			116	116	79	37,418	116	88.4%
CHESTER NURSING CENTER		CHESTER	CHESTER	CO	100	100	189	31,011	100	85.0%
CHESTER COUNTY		TOTAL			100	100	189	31,011	100	85.0%
TRINITY MISSION EDGEFIELD		EDGEFIELD	EDGEFIELD	PROP	120	120	80	41,294	120	94.3%
EDGEFIELD COUNTY		TOTAL			120	120	80	41,294	120	94.3%
FAIRFIELD HEALTHCARE CENTER		FAIRFIELD	RIDGEWAY	PROP	112	112	88	39,105	112	95.7%
UNIHEALTH POST ACUTE - TANGLEWOOD	12	FAIRFIELD	RIDGEWAY	PROP	150	150	204	50,346	150	92.0%
FAIRFIELD COUNTY		TOTAL			262	262	292	89,451	262	93.5%

REGION: II

INPATIENT INVENTORY FISCAL YEAR 2010

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
GREENWOOD REGIONAL REHAB HOSPITAL		GREENWOOD	GREENWOOD	NPA	12	12	292	2,809	12	64.1%
HEALTH CARE CENTER OF WESLEY COMMONS		GREENWOOD	GREENWOOD	NPA	102	102	220	31,839	102	85.5%
MAGNOLIA MANOR - GREENWOOD		GREENWOOD	GREENWOOD	PROP	88	88	60	31,495	88	98.1%
NHC HEALTHCARE - GREENWOOD		GREENWOOD	GREENWOOD	PROP	152	152	117	52,458	152	94.6%
GREENWOOD COUNTY		TOTAL			354	354	689	118,601	354	91.8%
KERSHAW KARESH LONG TERM CARE CENTER	13	KERSHAW	CAMDEN	CO	96	96	293	33,149	96	94.6%
SPRINGDALE HEALTHCARE CENTER		KERSHAW	CAMDEN	PROP	148	148	390	52,908	148	97.9%
KERSHAW COUNTY		TOTAL			244	244	683	86,057	244	96.6%
LANCASTER CONVALESCENT CENTER		LANCASTER	LANCASTER	NPA	142	142	93	50,031	142	96.5%
TRANSITIONAL CARE UNIT - SPRINGS MEMORIAL		LANCASTER	LANCASTER	NPA	14	14	362	3,864	14	75.6%
WHITE OAK MANOR - LANCASTER		LANCASTER	LANCASTER	NPA	132	132	90	47,186	132	97.9%
LANCASTER COUNTY		TOTAL			288	288	545	101,081	288	96.2%
LAURENS COUNTY HEALTHCARE SYSTEM SNF		LAURENS	LAURENS	DIST	14	14	171	2,682	14	52.5%
MARTHA FRANK BAPTIST RETIREMENT CENTER		LAURENS	LAURENS	NPA	81	81	41	27,780	81	94.0%
(MARTHA FRANK BAPTIST RETIREMENT CENTER)		LAURENS	LAURENS	NPA	(7)	(7)				
NHC HEALTHCARE - CLINTON		LAURENS	CLINTON	PROP	131	131	122	45,944	131	96.1%
NHC HEALTHCARE - LAURENS		LAURENS	LAURENS	PROP	176	176	379	61,014	176	95.0%
PRESBYTERIAN HOME OF SC CLINTON		LAURENS	CLINTON	NPA	18	18	31	5,602	18	85.3%
(PRESBYTERIAN HOME OF SC CLINTON)		LAURENS	CLINTON	NPA	(48)	(48)				
LAURENS COUNTY		TOTAL			420	420	744	143,022	420	93.3%
AGAPE NURSING AND REHABILIATION CENTER		LEXINGTON	W.COLUMBIA	PROP	100	100	555	34,410	100	94.3%
BRIAN CENTER NURSING CARE - ST ANDREWS		LEXINGTON	COLUMBIA	PROP	120	120	152	41,924	120	95.7%
HEARTLAND LEXINGTON REHAB & NURSING CTR		LEXINGTON	W.COLUMBIA	PROP	132	132	358	39,872	132	82.8%
LEXINGTON MEDICAL CENTER EXTENDED CARE		LEXINGTON	LEXINGTON	NPA	388	388	674	136,375	388	96.3%
NHC HEALTHCARE - LEXINGTON	14	LEXINGTON	W.COLUMBIA	PROP	120	170	302	42,489	120	97.0%
PRESBYTERIAN HOME OF SC COLUMBIA		LEXINGTON	W COLUMBIA	NPA	44	44	59	13,741	44	85.6%
SC EPISCOPAL HOME AT STILL HOPES	15	LEXINGTON	W.COLUMBIA	NPA	62	62	12	6,600	20	90.4%
(SC EPISCOPAL HOME AT STILL HOPES)		LEXINGTON	W.COLUMBIA	NPA	(0)	(0)				
LEXINGTON COUNTY		TOTAL			966	1,016	2,112	315,411	924	93.5%
PETRA HEALTH & REHAB MCCORMICK		MCCORMICK	MCCORMICK	CO	120	120	100	42,374	120	96.7%
MCCORMICK COUNTY		TOTAL			120	120	100	42,374	120	96.7%
J F HAWKINS NURSING HOME		NEWBERRY	NEWBERRY	CO	118	118	88	41,844	118	97.2%
(NEWBERRY CO MEM HOSP - TRANS CARE UNIT)	16	NEWBERRY	NEWBERRY	CO	(0)	(0)	163	1,476	12	33.7%
WHITE OAK OF NEWBERRY		NEWBERRY	NEWBERRY	PROP	146	146	67	51,766	146	97.1%
NEWBERRY COUNTY					264	264	318	95,086	276	94.4%
COUNTRYWOOD NURSING CENTER		RICHLAND	HOPKINS	PROP	38	38	43	12,902	38	93.0%
HEARTLAND COLUMBIA REHAB & NURSING CTR		RICHLAND	COLUMBIA	PROP	132	132	368	40,554	132	84.2%
HERITAGE AT LOWMAN REHAB & HEALTHCARE	17	RICHLAND	WHITE ROCK	NPA	176	176	188	59,214	176	92.2%
LIFE CARE CENTER OF COLUMBIA		RICHLAND	COLUMBIA	PROP	179	179	449	59,642	179	91.3%
MAGNOLIA MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	88	88	123	30,282	88	94.3%
NHC HEALTHCARE - PARKLANE		RICHLAND	COLUMBIA	PROP	180	180	332	62,729	180	95.5%
PALMETTO HEALTH BAPTIST SUBACUTE REHAB		RICHLAND	COLUMBIA	NPA	22	22	597	5,641	22	70.2%
RICE ESTATE REHAB & HEALTHCARE	18	RICHLAND	COLUMBIA	NPA	36	36	60	10,607	32	90.8%
UNI-HEALTH POST ACUTE CARE BLYTHEWOOD	19	RICHLAND	BLYTHEWOOD	PROP	120	120	0			
UNI-HEALTH POST ACUTE CARE COLUMBIA	19	RICHLAND	COLUMBIA	PROP	185	189	328	64,897	257	69.2%
WHITE OAK MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	120	120	132	41,198	120	94.1%
WILDEWOOD DOWNS NURSING CENTER		RICHLAND	COLUMBIA	PROP	72	72	282	17,411	72	66.3%
(WILDEWOOD DOWNS NURSING CENTER)		RICHLAND	COLUMBIA	PROP	(8)	(8)				
(W J B DORN VA)	5	RICHLAND	COLUMBIA	FED		(94)				
RICHLAND COUNTY		TOTAL			1,348	1,352	2,902	405,077	1,296	85.6%
SALUDA NURSING CENTER		SALUDA	SALUDA	CO	176	176	122	61,833	176	96.3%
SALUDA COUNTY		TOTAL			176	176	122	61,833	176	96.3%

REGION: II

INPATIENT INVENTORY **FISCAL YEAR 2010**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
AGAPE REHABILITATION ROCK HILL		YORK	ROCK HILL	PROP	99	99	327	33,076	99	91.5%
MAGNOLIA MANOR - ROCK HILL		YORK	ROCK HILL	PROP	106	106	144	35,147	106	90.8%
UNI-HEALTH POST ACUTE CARE ROCK HILL		YORK	ROCK HILL	PROP	132	132	403	44,001	132	91.3%
WESTMINSTER HEALTH & REHABILITATION CTR		YORK	ROCK HILL	PROP	66	66	236	21,538	66	89.4%
WHITE OAK OF ROCK HILL		YORK	ROCK HILL	PROP	141	141	108	50,120	141	97.4%
WHITE OAK MANOR - YORK		YORK	YORK	NPA	109	109	85	39,357	109	98.9%
WILLOW BROOK COURT		YORK	ROCK HILL	PROP	40	40	112	6,066	40	41.5%
YORK COUNTY		TOTAL			693	693	1,415	229,305	693	90.7%
TOTAL					5,471	5,525	10,270	1,797,021	5,389	91.4%

FOOTNOTES 2012-13 PLAN

REGION II

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON approved 8/22/08 to convert 18 substance abuse beds to general beds, for a total of 217 general beds. The CON was appealed; the application was withdrawn 3/22/11 and the facility remains licensed for 199 acute and 18 substance abuse beds.
2. CON approved 10/20/09 to add 30 beds for a total of 414; appealed. CON issued 1/21/10, SC-10-6. Licensed for 414 beds 8/25/10.
3. CON approved to construct a new 76 bed hospital (Palmetto Health Parkridge) by transferring 76 beds from Palmetto Health Baptist, resulting in 287 general beds, 104 psych and 22 nursing home beds remaining at Palmetto Health Baptist; appealed. CON issued 6/8/10, SC-10-16.
4. CON approved 8/27/07 to add 38 general beds for a total of 84 beds; appealed. SC-09-10 issued 3/3/09 after the appeal was withdrawn. Licensed beds increased from 46 to 56 on 12/3/09.
5. Bed use restricted. Beds reported by facility.
6. CON approved 9/9/11 to build a 50 bed hospital; appealed.
7. Licensed 10 additional beds for a total of 30 RTF beds, 1/20/11.
8. CON issued 7/29/11 to add 8 rehab beds for a total of 42 rehab beds and 12 nursing home beds, SC-11-27.
9. CON issued 6/30/09 to add 6 rehab beds for a total of 46, SC-09-32; licensed for 46 beds 7/9/10. CON issued 9/22/11 to add 4 rehab beds for a total of 50, SC-11-41. Licensed for 50 rehab beds 2/9/12.
10. Former facility (Heartland Hospice House of the Midlands) de-licensed. CON issued 5/13/11 to establish a 12 bed inpatient hospice, SC-11-14. Licensed 8/8/11.
11. Facility closed 1/1/11.
12. Formerly Heritage Healthcare of Ridgeway.
13. Formerly A. Sam Karesh Long Term Care Center.
14. CON issued 12/28/11 to add 50 nursing home beds for a total of 170 beds, SC-11-52.
15. CON issued 12/28/11 to convert 42 institutional nursing home beds to community beds, for a total of 62 community and 0 institutional beds, SC-11-53.
16. Transitional Care Unit closed 6/30/11.
17. CON approved 2/23/10 to convert 47 beds from institutional to community for a total of 176 community beds. License amended 3/24/10.
18. CON issued 7/1/11 to add 4 nursing home beds for a total of 36, SC-11-21. Licensed for 36 beds 10/7/11.
19. CON issued 1/29/07 for the construction of a 123 bed nursing home with a Medicaid Nursing Home Permit of 21,900 Medicaid patient days by transferring 89 beds from Carolina Health and Rehab and adding 34 new beds. Carolina Health and Rehab retained 168 nursing home beds and a Medicaid Nursing Home Permit for 47,100 Medicaid patient days; SC-07-04. Name of Carolina Health and Rehab changed to UniHealth Post-Acute Columbia 6/20/08. CON amended 5/14/08 to reduce the number of beds at the Oaks of Blythewood from 123 to

120, with the number of beds retained at UniHealth Post-Acute Columbia increased from 168 to 171. UniHealth Post-Acute Care – Blythewood (formerly Oaks of Blythewood) licensed for 120 beds 8/20/10; UniHealth Post-Acute Columbia licensed beds decreased to 171 the same day. CON issued 1/31/11 to license 18 additional beds at UniHealth Post-Acute Columbia, for a total of 189 beds, SC-11-01. Licensed 14 additional beds for a total of 185 on 10/11/11.

INVENTORY OF EMERGENCY FACILITIES

CATEGORY	NAME OF FACILITY	2009 ER VISITS	2010 ER VISITS
REGION II:	EMERGENCY FACILITIES		
III	ABBEVILLE CO MEMORIAL HOSPITAL	10,721	10,783
II	CHESTER MEDICAL CENTER	17,380	16,875
III	EDGEFIELD COUNTY HOSPITAL	5,817	5,793
III	FAIRFIELD MEMORIAL HOSPITAL	11,547	11,404
II	SELF REGIONAL HEALTH CARE	44,733	44,181
III	KERSHAW HEALTH	26,442	26,121
II	SPRINGS MEMORIAL HOSPITAL	32,515	31,278
II	LAURENS COUNTY HOSPITAL	30,321	29,272
II	LEXINGTON MEDICAL CENTER	93,782	94,842
III	NEWBERRY CO MEMORIAL HOSPITAL	21,584	22,478
II	PALMETTO HEALTH BAPTIST	38,439	39,903
I	PALMETTO HEALTH RICHLAND	79,488	83,525
II	PROVIDENCE HOSPITAL	19,178	20,390
II	PROVIDENCE HOSPITAL NORTHEAST	35,152	33,554
II	PIEDMONT MEDICAL CENTER	53,339	49,162
		520,438	519,561

REGION II:	TRAUMA CENTERS
III	SELF MEM REGIONAL HEALTH CARE
III	LEXINGTON MEDICAL CENTER
I	PALMETTO HEALTH RICHLAND
III	PIEDMONT MEDICAL CTR

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: III

FISCAL YEAR: 2010

1. Unusual Characteristics: This region has a large transient summer population, particularly along the "Grand Strand." The inland waterway is a barrier to transportation.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only.

3. Nursing Homes: There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter IV for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter VI for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter V for discussion and calculation of needs.

REGION: III **INPATIENT INVENTORY** **FISCAL YEAR 2010**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
CHESTERFIELD GENERAL HOSPITAL		CHESTERFIELD	CHERAW	PROP	59	59	2,411	9,151	59	42.5%
CHESTERFIELD COUNTY		TOTAL			59	59	2,411	9,151	59	42.5%
CLARENDON MEMORIAL HOSPITAL	1	CLARENDON	MANNING	CO	81	81	2,736	12,438	56	60.9%
CLARENDON COUNTY		TOTAL			81	81	2,736	12,438	56	60.9%
CAROLINA PINES REGIONAL MEDICAL CENTER		DARLINGTON	HARTSVILLE	NPA	116	116	6,381	22,505	116	53.2%
MCLEOD MEDICAL CENTER - DARLINGTON		DARLINGTON	DARLINGTON	NPA	49	49	1,194	3,209	49	17.9%
DARLINGTON COUNTY		TOTAL			165	165	7,575	25,714	165	42.7%
MCLEOD MEDICAL CENTER - DILLON		DILLON	DILLON	NPA	79	79	3,105	11,956	79	41.5%
DILLON COUNTY		TOTAL			79	79	3,105	11,956	79	41.5%
CAROLINAS HOSPITAL SYSTEM		FLORENCE	FLORENCE	PROP	310	310	7,553	68,379	310	60.4%
LAKE CITY COMMUNITY HOSPITAL		FLORENCE	LOWER FLOREN(	DIST	48	48	1,367	3,246	48	18.5%
MCLEOD REGIONAL MEDICAL CENTER		FLORENCE	FLORENCE	NPA	453	453	23,476	116,495	453	70.5%
WOMEN'S CENTER CAROLINAS HOSP SYSTEM		FLORENCE	FLORENCE	PROP	20	20	811	2,853	20	39.1%
FLORENCE COUNTY		TOTAL			831	831	33,207	190,973	831	63.0%
GEORGETOWN MEMORIAL HOSPITAL	2	GEORGETOWN	GEORGETOWN	NPA	131	131	6,068	25,881	131	54.0%
WACCAMAW COMMUNITY HOSPITAL		GEORGETOWN	MURRELLS INLET	NPA	124	124	8,128	26,212	124	57.8%
GEORGETOWN CQUNTY		TOTAL			255	255	14,196	52,093	255	55.8%
CONWAY HOSPITAL		HORRY	CONWAY	NPA	210	210	8,940	34,334	160	58.8%
GRAND STRAND REGIONAL MEDICAL CENTER	3	HORRY	MYRTLE BEACH	PROP	259	269	14,235	61,308	219	76.7%
LORIS COMMUNITY HOSPITAL		HORRY	LORIS	DIST	105	105	3,910	15,089	105	39.4%
SEACOAST MEDICAL CENTER	4	HORRY	LITTLE RIVER	DIST	50	50				
HORRY COUNTY		TOTAL			624	634	27,085	110,731	484	62.7%
MARION REGIONAL HOSPITAL	5	MARION	MARION	DIST	124	124		0	124	0.0%
MARION COUNTY		TOTAL			124	124	0	0	124	0.0%
MARLBORO PARK HOSPITAL		MARLBORO	BENNETTSVILLE	PROP	94	94	1,440	4,957	94	14.4%
MARLBORO COUNTY		TOTAL			94	94	1,440	4,957	94	14.4%
TUOMEY		SUMTER	SUMTER	NPA	283	283	8,740	65,403	283	63.3%
SUMTER COUNTY		TOTAL			283	283	8,740	65,403	283	63.3%
WILLIAMSBURG REGIONAL HOSPITAL		WILLIAMSBURG	KINGSTREE	CO	25	25	776	3,467	25	38.0%
WILLIAMSBURG COUNTY		TOTAL			25	25	776	3,467	25	38.0%
TOTAL					2,620	2,630	101,271	486,883	2,455	54.3%
LONG TERM ACUTE HOSPITALS:										
REGENCY HOSPITAL OF FLORENCE	6	FLORENCE	FLORENCE	PROP	40	40	487	12,467	40	85.4%
TOTAL					40	40	487	12,467	40	85.4%
MENTAL FACILITIES:										
MCLEOD MEDICAL CENTER - DARLINGTON		DARLINGTON	DARLINGTON	NPA	23	23	612	4,909	23	58.5%
DARLINGTON COUNTY		TOTAL			23	23	612	4,909	23	58.5%
CAROLINAS HOSP SYS - CEDAR TOWERS		FLORENCE	FLORENCE	PROP	12	12	257	2,015	12	46.0%
FLORENCE COUNTY		TOTAL			12	12	257	2,015	12	46.0%
LIGHTHOUSE CARE CENTER OF CONWAY	7	HORRY	CONWAY	PROP	44	59	1,040	12,837	44	79.9%
HORRY COUNTY		TOTAL			44	59	1,040	12,837	44	79.9%
MARLBORO PARK HOSPITAL		MARLBORO	BENNETTSVILLE	PROP	8	8	0	1,032	8	35.3%
MARLBORO COUNTY		TOTAL			8	8	0	1,032	8	35.3%
TOTAL					87	102	1,909	20,793	87	65.5%

REGION: III

INPATIENT INVENTORY FISCAL YEAR 2010

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
PALMETTO PEE DEE RES TREATMENT CTR		FLORENCE	FLORENCE	PROP	59	59	49	21,419	59	99.5%
LIGHTHOUSE CARE CENTER OF CONWAY		HORRY	CONWAY	PROP	30	30	42	7,519	30	68.7%
WILLOWGLEN ACADEMY SOUTH CAROLINA	8	WILLIAMSBURG	KINGSTREE	PROP	40	54	25	5,820	40	39.9%
TOTAL					129	143	116	34,758	129	73.6%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
CAROLINAS HOSPITAL SYSTEM - CEDAR TOWERS		FLORENCE	FLORENCE	PROP	12	12	178	1,837	12	41.9%
LIGHTHOUSE CARE CENTER OF CONWAY	7	HORRY	CONWAY	PROP	8	14	485	2,847	8	97.5%
TOTAL					20	26	663	4,684	20	64.2%
REHABILITATION FACILITIES:										
CAROLINAS HOSPITAL SYSTEM - CEDAR TOWERS		FLORENCE	FLORENCE	NPA	42	42	689	10,592	42	69.1%
HEALTHSOUTH REHAB HOSPITAL FLORENCE		FLORENCE	FLORENCE	PROP	88	88	1,084	15,786	88	49.1%
FLORENCE COUNTY		TOTAL			130	130	1,773	26,378	130	55.6%
WACCAMAW COMMUNITY HOSPITAL		GEORGETOWN	MURRELLS INLET	NPA	43	43	1,064	13,417	43	85.5%
GEORGETOWN COUNTY		TOTAL			43	43	1,064	13,417	43	85.5%
TOTAL					173	173	2,837	39,795	173	63.0%
INPATIENT HOSPICE FACILITIES:										
MCLEOD HOSPICE HOUSE	9	FLORENCE	FLORENCE	NPA	12	24	566	3,858	12	88.1%
TIDELANDS COMMUNITY HOSPICE HOUSE		GEORGETOWN	GEORGETOWN	NPA	12	12	222	2,203	12	50.3%
(AGAPE HOSPICE HOUSE OF HORRY COUNTY)	10	HORRY	CONWAY	PROP	(24)	(24)				
MERCY CARE HOSPICE HOUSE CONWAY	11	HORRY	CONWAY	NPA		14				
TOTAL					24	50	788	6,061	24	69.2%
LONG TERM FACILITIES:										
CHERAW HEALTHCARE		CHESTERFIELD	CHERAW	PROP	120	120	79	42,982	120	98.1%
CHESTERFIELD CONVALESCENT CENTER		CHESTERFIELD	CHERAW	PROP	104	104	70	35,759	104	94.2%
CHESTERFIELD COUNTY		TOTAL			224	224	149	78,741	224	96.3%
LAKE MARION NURSING FACILITY		CLARENDON	SUMMERTON	PROP	88	88	61	29,479	88	91.8%
WINDSOR MANOR		CLARENDON	MANNING	PROP	64	64	26	21,344	64	91.4%
CLARENDON COUNTY		TOTAL			152	152	87	50,823	152	91.6%
BETHEA BAPTIST HEALTH CARE CENTER		DARLINGTON	DARLINGTON	NPA	36	36	52	11,075	36	84.3%
(BETHEA BAPTIST HEALTH CARE CENTER)		DARLINGTON	DARLINGTON	NPA	(52)	(52)				
MEDFORD NURSING CENTER		DARLINGTON	DARLINGTON	PROP	88	88	45	30,607	88	95.3%
MORRELL NURSING CENTER		DARLINGTON	HARTSVILLE	PROP	154	154	298	51,679	154	91.9%
OAKHAVEN NURSING CENTER		DARLINGTON	DARLINGTON	PROP	88	88	59	30,204	88	94.0%
DARLINGTON COUNTY		TOTAL			366	366	454	123,565	366	92.5%
HERITAGE HEALTHCARE AT THE PINES		DILLON	DILLON	PROP	84	84	68	29,394	84	95.9%
SUNNY ACRES		DILLON	FORK	PROP	111	111	62	38,690	111	95.5%
DILLON COUNTY		TOTAL			195	195	130	68,084	195	95.7%
CAROLINAS HOSP SYS TRANS CARE UNIT		FLORENCE	FLORENCE	PROP	24	24	356	5,190	24	59.2%
COMMANDER NURSING CENTER		FLORENCE	FLORENCE	PROP	163	163	68	58,426	163	98.2%
FAITH HEALTHCARE CENTER		FLORENCE	FLORENCE	PROP	104	104	179	32,026	104	84.4%
FLORENCE REHAB & NURSING CENTER		FLORENCE	FLORENCE	PROP	88	88	88	29,566	88	92.0%

REGION: III **INPATIENT INVENTORY** **FISCAL YEAR 2010**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HERITAGE HOME OF FLORENCE		FLORENCE	FLORENCE	PROP	132	132	101	46,748	132	97.0%
HONORAGE NURSING CENTER		FLORENCE	FLORENCE	PROP	88	88	88	30,947	88	96.3%
LAKE CITY - SCRANTON HEALTH CARE CTR		FLORENCE	SCRANTON	PROP	88	88	234	30,015	88	93.4%
SOUTHLAND HEALTH CARE CENTER		FLORENCE	FLORENCE	PROP	88	88	40	31,353	88	97.6%
FLORENCE COUNTY		TOTAL			775	775	1,154	264,271	775	93.4%
GEORGETOWN HEALTH AND REHAB		GEORGETOWN	GEORGETOWN	PROP	84	84	61	26,158	84	85.3%
LAKES AT LITCHFIELD SKILLED NURS CTR		GEORGETOWN	PAWLEYS ISLANI	PROP	17	17	108	5,300	17	85.2%
(LAKES AT LITCHFIELD SKILLED NURS CTR)		(GEORGETOWN)	(PAWLEYS ISLAN	(PROP)	(7)	(7)				
PRINCE GEORGE HEALTHCARE CENTER	12	GEORGETOWN	GEORGETOWN	PROP	148	148			148	0.0%
GEORGETOWN COUNTY		TOTAL			249	249	169	31,458	249	34.6%
AGAPE REHABILITATION CTR CONWAY	13	HORRY	CONWAY	PROP	95	95	441	11,021	72	41.8%
BRIGHTWATER SKILLED NURSING CENTER	14	HORRY	MYRTLE BEACH	PROP	67	67	265	8,321	23.1	98.4%
CONWAY MANOR		HORRY	CONWAY	PROP	190	190	242	64,702	190	93.3%
COVENANT TOWERS HEALTH CARE		HORRY	MYRTLE BEACH	PROP	30	30	123	8,694	30	79.4%
GRAND STRAND HEALTH CARE		HORRY	CONWAY	PROP	88	88	95	31,022	88	96.6%
KINGSTON NURSING CENTER		HORRY	CONWAY	PROP	88	88	302	30,419	88	94.7%
LORIS EXTENDED CARE CENTER		HORRY	LORIS	DIST	88	88	247	29,523	88	91.9%
MYRTLE BEACH MANOR	15	HORRY	MYRTLE BEACH	PROP	100	100	319	27,251	100.6	74.2%
NHC HEALTHCARE - GARDEN CITY		HORRY	MYRTLE BEACH	PROP	148	148	520	49,371	148	91.4%
SEASIDE LIVING CENTER	16	HORRY	MYRTLE BEACH	PROP	0	60				
SHEPHERD'S LANDING NURSING & REHAB CTR	17	HORRY	LITTLE RIVER	PROP	0	60				
HORRY COUNTY		TOTAL			894	1,014	2,554	260,324	827.7	86.2%
MCCOY MEMORIAL NURSING CENTER		LEE	BISHOPVILLE	PROP	120	120	136	42,479	120	97.0%
LEE COUNTY		TOTAL			120	120	136	42,479	120	97.0%
MARION NURSING CENTER		MARION	MARION	PROP	88	88	40	30,468	88	94.9%
MULLINS NURSING CENTER		MARION	MARION	NPA	92	92	41	33,212	92	98.9%
MARION COUNTY		TOTAL			180	180	81	63,680	180	96.9%
DUNDEE MANOR		MARLBORO	BENNETTSVILLE	PROP	110	110	69	37,963	110	94.6%
MARLBORO COUNTY		TOTAL			110	110	69	37,963	110	94.6%
COVENANT PLACE NURSING CENTER	18	SUMTER	SUMTER	PROP	28	28	14	4,703	28	46.0%
(COVENANT PLACE NURSING CENTER)		(SUMTER)	(SUMTER)	(PROP)	(0)	(0)				
NHC HEALTHCARE - SUMTER		SUMTER	SUMTER	PROP	138	138	128	48,910	138	97.1%
SUMTER EAST HEALTH & REHAB CENTER		SUMTER	SUMTER	PROP	176	176	167	62,284	176	97.0%
SUMTER VALLEY NURSING & REHAB CENTER	19	SUMTER	SUMTER	PROP	96	96			96	0.0%
TUOMEY SUBACUTE SKILLED CARE		SUMTER	SUMTER	NPA	18	18	431	4,710	18	71.7%
SUMTER COUNTY		TOTAL			456	456	740	120,607	456	72.5%
DR. RONALD E. MCNAIR NURSING & REHAB		WILLIAMSBURG	CADES	PROP	88	88	63	27,135	88	84.5%
KINGSTREE NURSING FACILITY		WILLIAMSBURG	KINGSTREE	PROP	96	96	76	29,576	96	84.4%
WILLIAMSBURG COUNTY		TOTAL			184	184	139	56,711	184	84.2%
TOTAL					3,905	4,025	5,862	1,198,706	3,839	85.6%

FOOTNOTES 2012-13 PLAN

REGION III

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON issued 10/27/08 to add 25 beds for a total of 81 beds, SC-08-44. Licensed 5/29/12.
2. CON issued 3/2/09 to construct a replacement of the existing hospital, with a decrease in bed capacity from 131 to 129 beds, SC-09-09. CON voided 12/15/10.
3. CON issued 9/24/07 to add 50 general acute beds for a total of 269, SC-07-45. Licensed 40 additional beds for a total of 259, 5/1/11. Licensed for 269 beds 4/19/12.
4. CON approved 8/29/05 to establish a hospital with 50 general acute beds; appealed. CON issued per ALJ Order 9/28/07, SC-07-47. Facility licensed 7/6/11.
5. Facility failed to provide utilization data for 2010.
6. Formerly Regency Hospital of South Carolina.
7. CON approved to add 15 psych beds, for a total of 59, and 6 inpatient substance abuse beds, for a total of 14; appealed. Appeal withdrawn, CON SC-10-07 issued 1/25/10.
8. Converted 40 beds from a High Maintenance Group Home to Residential Treatment Facility beds on 3/20/09; intend to license 54 RTF beds. Facility relocated from Greeleyville to Kingstree 4/14/11.
9. CON issued 3/11/10 to add 12 beds for a total of 24, SC-10-10.
10. CON issued 3/5/07 for a 24-bed inpatient hospice, SC-07-08. Licensed 3/31/09. CON issued 7/15/10 to convert the 24 inpatient hospice beds to nursing home beds for a total of 96 nursing home beds, SC-10-21.
11. CON issued 3/23/12 to establish a 14 bed inpatient hospice, SC-12-09.
12. Facility failed to provide utilization data for 2010.
13. issued 3/5/07 for a 72-bed nursing home that does not participate in the Medicaid program/ SC-07-07. Facility licensed 3/18/09. CON issued 7/15/10 to convert the 24 inpatient hospice beds to nursing home beds for a total of 96 nursing home beds, SC-10-21. Facility licensed for 95 beds 4/1/11. Because of the need for an isolation room, the remaining bed approved under SC-10-11 was voided.
14 CON issued 5/9/08 for a 32-bed nursing home that does not participate in the Medicaid program, SC-08-15. Licensed 4/13/09. CON issued 1/31/11 to add 35 beds, for a total of 67 beds, SC-11-06. Licensed for 67 beds 8/17/11.
15 De-licensed 4 nursing home beds for a total of 100 beds, 2/22/10.
16 CON issued 10/14/10 for a 60 bed nursing home that does not participate in the Medicaid program, SC-10-30.
17 CON issued 3/12/09 for a 60 bed nursing home that does not participate in the Medicaid program, SC-09-12.
18 CON issued 1/31/11 to convert 28 institutional nursing home beds to community beds that do not participate in the Medicaid program, for a total of 16 institutional and 28 community beds, SC-11-03. Licensed for 28 community beds 6/21/11.
19. Formerly Hopewell Health Care Center.

INVENTORY OF EMERGENCY FACILITIES

CATEGORY	NAME OF FACILITY	2009 ER VISITS	2010 ER VISITS
REGION III:	EMERGENCY FACILITIES		
II	CHESTERFIELD GENERAL HOSPITAL	13,336	12,582
III	CLARENDON MEMORIAL HOSPITAL	18,068	17,475
III	CAROLINA PINES REGIONAL MED CTR	32,627	32,070
III	MCLEOD - DILLON	25,419	24,967
III	CAROLINAS HOSPITAL SYSTEM	36,346	34,349
II	MCLEOD REGIONAL MED CENTER	60,247	53,719
III	LAKE CITY COMMUNITY HOSPITAL	15,296	15,221
II	GEORGETOWN MEMORIAL HOSPITAL	31,990	29,775
II	WACCAMAW COMMUNITY HOSPITAL	26,252	26,418
II	CONWAY HOSPITAL	43,813	46,276
III	LORIS COMMUNITY HOSPITAL	41,227	40,511
II	GRAND STRAND REGIONAL MED CTR	67,167	69,202
III	MARION COUNTY MEDICAL CENTER *1*	23,275	0
III	MARLBORO PARK HOSPITAL	14,971	14,452
II	TUOMEY	54,755	54,579
III	WILLIAMSBURG REGIONAL	11,027	10,603
		515,816	482,199

1 FACILITY FAILED TO PROVIDE DATA FOR 2010

REGION III:	TRAUMA CENTERS
III	CAROLINA PINES REGIONAL MED CTR
III	CAROLINAS HOSPITAL SYSTEM
III	MCLEOD REGIONAL MED CENTER
III	GRAND STRAND REGIONAL MED CTR

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: IV

FISCAL YEAR: 2010

1. Unusual Characteristics: This region has a military presence in Charleston. A naval hospital provides health care services for the active duty and dependents residing in this region. A 376 bed Veterans Administration Hospital is located in Charleston. The only medical university hospital in the State is located in Charleston. The Marine Air Base and Parris Island Marine Base are located near Beaufort with naval hospital to provide care to the active duty and dependents. The sea islands, rivers and sounds are barriers to transportation.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only.

3. Nursing Homes: There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter IV for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter VI for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter V for discussion and calculation of needs.

REGION: IV **INPATIENT INVENTORY** **FISCAL YEAR 2010**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	183	183	8,875	41,249	183	61.8%
AIKEN COUNTY		TOTAL			183	183	8,875	41,249	183	61.8%
ALLENDALE COUNTY HOSPITAL		ALLENDALE	FAIRFAX	CO	25	25	276	942	25	10.3%
ALLENDALE COUNTY		TOTAL			25	25	276	942	25	10.3%
(BAMBERG COUNTY MEMORIAL)	1	BAMBERG	BAMBERG	CO	59	(0)	1,541	4,414	59	20.5%
BAMBERG COUNTY		TOTAL			59	(0)	1,541	4,414	59	20.5%
BARNWELL COUNTY HOSPITAL		BARNWELL	BARNWELL	CO	53	53	1,175	2,809	53	14.5%
BARNWELL COUNTY		TOTAL			53	53	1,175	2,809	53	14.5%
BEAUFORT COUNTY MEMORIAL		BEAUFORT	BEAUFORT	CO	169	169	9,224	37,279	169	60.4%
HILTON HEAD HOSPITAL		BEAUFORT	HILTON HEAD	NPA	93	93	4,999	18,276	93	53.8%
NAVAL HOSPITAL	2	BEAUFORT	BEAUFORT	FED		(64)				
BEAUFORT COUNTY		TOTAL			262	262	14,223	55,555	262	58.1%
BERKELEY MEDICAL CENTER	3	BERKELEY	MONCKS CORNE	PROP		50				
ROPER ST FRANCIS HOSPITAL - BERKELEY	4	BERKELEY	GOOSE CREEK	NPA		50				
BERKELEY COUNTY		TOTAL			0	100				
BON-SECOURS ST. FRANCIS XAVIER		CHARLESTON	CHARLESTON	NPA	204	204	8,290	32,609	204	43.8%
EAST COOPER MEDICAL CENTER	5	CHARLESTON	MT PLEASANT	PROP	130	130	4,801	15,236	123.6	33.8%
MEDICAL UNIVERSITY HOSPITAL	6	CHARLESTON	CHARLESTON	ST	604	604	29,237	158,797	600	72.5%
ROPER HOSPITAL	4	CHARLESTON	CHARLESTON	NPA	316	266	14,278	72,121	383.5	51.5%
ROPER ST. FRANCIS MOUNT PLEASANT HOSPITAL	4	CHARLESTON	MT PLEASANT	NPA	85	85	188	636	14.2	12.3%
TRIDENT MEDICAL CENTER		CHARLESTON	CHARLESTON	PROP	296	296	15,191	70,116	296	64.9%
RALPH H JOHNSON VETERANS MEDICAL CTR	2	CHARLESTON	CHARLESTON	FED		(144)				
CHARLESTON COUNTY		TOTAL			1,635	1,585	71,985	349,515	1,621.3	59.1%
COLLETON MEDICAL CENTER		COLLETON	WALTERBORO	PROP	131	131	4,176	20,893	131	43.7%
COLLETON COUNTY		TOTAL			131	131	4,176	20,893	131	43.7%
SUMMERVILLE MEDICAL CENTER	7	DORCHESTER	SUMMERVILLE	PROP	94	124	6,229	22,442	94	65.4%
DORCHESTER COUNTY		TOTAL			94	124	6,229	22,442	94	65.4%
HAMPTON REGIONAL MEDICAL CENTER		HAMPTON	VARNVILLE	CO	32	32	923	3,797	32	32.5%
HAMPTON COUNTY		TOTAL			32	32	923	3,797	32	32.5%
COASTAL CAROLINA MEDICAL CENTER	8	JASPER	HARDEEVILLE	PROP	41	41	1,230	4,245	31	37.5%
JASPER COUNTY		TOTAL			41	41	1,230	4,245	31	37.5%
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	247	247	9,923	50,588	247	56.1%
ORANGEBURG COUNTY		TOTAL			247	247	9,923	50,588	247	56.1%
TOTAL					2,762	2,783	120,556	556,449	2,738	55.7%
LONG TERM ACUTE HOSPITALS:										
PACE HEALTHCARE COMMONS	9	BEAUFORT	BLUFFTON	PROP		32				
KINDRED HOSPITAL - CHARLESTON	10	CHARLESTON	CHARLESTON	PROP	59	59	242	10,309	59	47.9%
TOTAL					59	91	242	10,309	59	47.9%
MENTAL FACILITIES:										
AIKEN REGIONAL MEDICAL CENTER	11	AIKEN	AIKEN	PROP	41	41	1,004	9,021	29	85.2%
AIKEN COUNTY		TOTAL			41	41	1,004	9,021	29	85.2%
BEACON HARBOR GERIATRIC PSYCHIATRIC CARE	12	BEAUFORT	BLUFFTON	PROP		22				
BEAUFORT MEMORIAL HOSPITAL		BEAUFORT	BEAUFORT	CO	14	14	364	2,693	14	52.7%
BEAUFORT COUNTY		TOTAL			14	36	364	2,693	14	52.7%
MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	82	82	2,368	17,097	82	57.1%
PALMETTO LOWCOUNTY BEHAVIORAL HEALTH		CHARLESTON	CHARLESTON	PROP	70	70	892	14,434	70	56.5%
RALPH H JOHNSON VETERANS MEDICAL CTR	2	CHARLESTON	CHARLESTON	FED		(36)				

REGION: IV **INPATIENT INVENTORY** **FISCAL YEAR 2010**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
CHARLESTON COUNTY		TOTAL			152	152	3,260	31,531	152	56.8%
COLLETON MEDICAL CENTER	13	COLLETON.	WALTERBORO	PROP	4	4				
COLLETON COUNTY		TOTAL			4	4				
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	15	15	351	2,853	15	52.1%
ORANGEBURG COUNTY		TOTAL			15	15	351	2,853	15	52.1%
TOTAL					226	248	4,979	46,098	210	60.1%
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
PALMETTO LOWCOUNTY BEHAV. HEALTH RTC		CHARLESTON	CHARLESTON	PROP	32	32	47	11,823	32	101.2%
RIVERSIDE BEHAVIORAL AT WINDWOOD FARM	14	CHARLESTON	AWENDAW	PROP	12	12	17	3,077	9.5	88.7%
PALMETTO PINES BEHAVIORAL HEALTH		SUMMERVILLE	DORCHESTER	PROP	60	60	46	21,455	60	98.0%
PINELANDS RESIDENTIAL TREATMENT CENTER	15	SUMMERVILLE	DORCHESTER	PROP	14	28	9	597	6.3	26.0%
TOTAL					118	132	119	36,952	107.8	93.7%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	18	18	833	6,184	18	94.1%
MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	23	23	645	3,617	23	43.1%
PALMETTO LOWCOUNTY BEHAVIORAL HEALTH		CHARLESTON	N CHARLESTON	PROP	10	10	647	4,612	10	126.4%
TOTAL					51	51	2,125	14,413	51	77.4%
REHABILITATION FACILITIES:										
PACE HEALTHCARE COMMONS	16	BEAUFORT	BLUFFTON	PROP		10				
BEAUFORT MEMORIAL HOSPITAL		BEAUFORT	BEAUFORT	CO	14	14	245	2,667	14	52.2%
BEAUFORT COUNTY		TOTAL			14	24	245	2,667	14	52.2%
ROPER HOSPITAL		CHARLESTON	CHARLESTON	NPA	52	52	1,024	14,038	52	74.0%
HEALTHSOUTH CHARLESTON	17	CHARLESTON	CHARLESTON	PROP	49	49	973	13,280	46	79.1%
CHARLESTON COUNTY		TOTAL			101	101	1,997	27,318	98	76.4%
(COASTAL CAROLINA MEDICAL CENTER)	8	JASPER	HARDEEVILLE	PROP	(0)	(0)	2	27	10	0.7%
JASPER COUNTY		TOTAL			0	0	2	27	10	0.7%
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	24	24	551	6,706	24	76.6%
ORANGEBURG COUNTY		TOTAL			24	24	551	6,706	24	76.6%
TOTAL					139	149	2,795	36,718	146	68.9%
INPATIENT HOSPICE FACILITIES:										
THE HOSPICE OF CHARLESTON		CHARLESTON	CHARLESTON	NPA	20	20	461	2,978	20	40.8%
TOTAL					20	20	461	2,978	20	40.8%
LONG TERM FACILITIES:										
ANCHOR HEALTH & REHAB AIKEN	18	AIKEN	AIKEN	PROP	60	60	534	20,506	60	93.6%
AZALEAWOODS REHAB & NURSING CENTER		AIKEN	AIKEN	PROP	86	86	55	30,175	86	96.1%
NHC HEALTHCARE N. AUGUSTA		AIKEN	N. AUGUSTA	PROP	192	192	332	61,307	192	87.2%
PEPPER HILL NURSING CENTER		AIKEN	AIKEN	PROP	132	132	112	43,906	132	91.1%
UNIHEALTH POST-ACUTE - AIKEN		AIKEN	AIKEN	PROP	176	176	369	59,973	176	93.1%
UNIHEALTH POST-ACUTE - NORTH AUGUSTA		AIKEN	N. AUGUSTA	PROP	132	132	208	42,725	132	88.4%
AIKEN COUNTY		TOTAL			778	778	1,610	258,592	778	91.1%
JOHN E HARTER NURSING HOME		ALLENDALE	FAIRFAX	CO	44	44	14	12,743	44	79.1%
ALLENDALE COUNTY		TOTAL			44	44	14	12,743	44	79.1%
UNIHEALTH POST-ACUTE CARE BAMBERG		BAMBERG	BAMBERG	CO	88	88	85	30,371	88	94.3%
BAMBERG COUNTY		TOTAL			88	88	85	30,371	88	94.3%

REGION: IV **INPATIENT INVENTORY** **FISCAL YEAR 2010**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
LAUREL BAYE HEALTHCARE OF BLACKVILLE		BARNWELL	BLACKVILLE	PROP	85	85	47	14,700	85	47.4%
LAUREL BAYE HEALTHCARE OF WILLISTON		BARNWELL	WILLISTON	PROP	44	44	89	15,107	44	94.1%
UNIHEALTH POST-ACUTE BARNWELL	19	BARNWELL	BARNWELL	CO	44	44	89	14,648	44	91.2%
BARNWELL COUNTY		TOTAL			173	173	225	44,455	173	70.4%
BAYVIEW MANOR		BEAUFORT	BEAUFORT	PROP	170	170	267	50,875	170	82.0%
BEACON HARBOR SUBACUTE CARE	20	BEAUFORT	BLUFTON	PROP	0	120				
BROAD CREEK CARE CENTER		BEAUFORT	HILTON HEAD	PROP	25	25	130	8,788	25	96.3%
LIFE CARE CENTER OF HILTON HEAD		BEAUFORT	HILTON HEAD	PROP	88	88	240	21,543	88	67.1%
FRASER HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	19	19	62	5,665	19	81.7%
(FRASER HEALTH CENTER)		(BEAUFORT)	(HILTON HEAD)	PROP	(14)	(14)				
NHC BLUFFTON	21	BEAUFORT	BLUFTON	PROP	120	120	238	10,875	113.1	26.3%
PRESTON HEALTH CARE CENTER		BEAUFORT	HILTON HEAD	PROP	69	69	145	15,633	69	62.1%
(PRESTON HEALTH CARE CENTER)		(BEAUFORT)	(HILTON HEAD)	PROP	(8)	(8)				
BEAUFORT COUNTY		TOTAL			491	611	1,082	113,379	484.1	64.2%
HEARTLAND HEALTH CARE CTR - CHARLESTON	22	BERKELEY	HANAHAN	PROP	135	135	415	33,310	105	86.9%
LAKE MOULTRIE NURSING HOME		BERKELEY	ST STEPHENS	PROP	88	88	40	30,655	88	95.4%
UNIHEALTH POST-ACUTE MONCKS CORNER		BERKELEY	MONCKS CORNE	PROP	132	132	161	45,459	132	94.4%
BERKELEY COUNTY		TOTAL			355	355	616	109,424	325	92.2%
CALHOUN CONVALESCENT CENTER		CALHOUN	ST. MATTHEWS	PROP	120	120	103	39,655	120	90.5%
CALHOUN COUNTY		TOTAL			120	120	103	39,655	120	90.5%
BISHOP GADSDEN EPISCOPAL HOME		CHARLESTON	CHARLESTON	NPA	41	41	57	13,156	41	87.7%
(BISHOP GADSDEN EPISCOPAL HOME)		CHARLESTON	CHARLESTON	NPA	(9)	(9)				
FRANKE HEALTH CARE CENTER	23	CHARLESTON	CHARLESTON	NPA	44	44	85	8,054	24	91.7%
(FRANKE HEALTH CARE CENTER)		CHARLESTON	CHARLESTON	NPA	(0)	(0)				
GRACE HALL - REHABILITATION		CHARLESTON	MT. PLEASANT	PROP	42	42	287	12,378	42	80.5%
HARVEST HEALTH & REHAB JOHNS ISLAND		CHARLESTON	CHARLESTON	NPA	132	132	169	46,720	132	96.7%
HEARTLAND WEST ASHLEY REHAB & NURSING CTR	24	CHARLESTON	CHARLESTON	NPA	99	125	592	32,647	99	90.3%
KINDRED HOSPITAL CHARLESTON SUBACUTE UNIT	10	CHARLESTON	MT. PLEASANT	PROP		35				
LIFE CARE CENTER - CHARLESTON		CHARLESTON	N CHARLESTON	PROP	148	148	716	51,672	148	95.7%
MOUNT PLEASANT MANOR		CHARLESTON	MT. PLEASANT	PROP	132	132	121	45,796	132	95.1%
NATIONAL HEALTH CARE CHARLESTON	25	CHARLESTON	CHARLESTON	PROP	88	88	642	25,550	132	53.0%
RIVERSIDE HEALTH & REHAB CENTER	26	CHARLESTON	CHARLESTON	PROP	160	160	227	31,000	160	52.9%
SANDPIPER REHAB & NURSING		CHARLESTON	MT. PLEASANT	PROP	176	176	286	60,955	176	94.9%
WHITE OAK MANOR - CHARLESTON		CHARLESTON	CHARLESTON	PROP	176	176	296	60,919	176	94.8%
CHARLESTON COUNTY		TOTAL			1,238	1,299	3,478	388,847	1,262	84.4%
UNIHEALTH POST-ACUTE CARE OAKWOOD	27	COLLETON	WALTERBORO	PROP	132	132	208	46,421	132	96.3%
COLLETON COUNTY		TOTAL			132	132	208	46,421	132	96.3%
HALLMARK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88	215	31,132	88	96.7%
OAKBROOK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88	196	30,133	88	93.6%
PRESBYTERIAN HOME SUMMERVILLE		DORCHESTER	SUMMERVILLE	NPA	87	87	163	28,375	87	89.4%
ST GEORGE HEALTH CARE CENTER		DORCHESTER	ST. GEORGE	PROP	88	88	223	29,878	88	93.0%
DORCHESTER COUNTY		TOTAL			351	351	797	119,518	351	93.3%
UNI-HEALTH POST ACUTE CARE - LOWCOUNTRY		HAMPTON	ESTILL	CO	104	104	104	34,420	104	90.7%
HAMPTON COUNTY		TOTAL			104	104	104	34,420	104	90.7%
RIDGELAND NURSING CENTER		JASPER	RIDGELAND	PROP	88	88	53	30,586	88	95.2%
JASPER COUNTY		TOTAL			88	88	53	30,586	88	95.2%
JOLLEY ACRES HEALTHCARE CENTER		ORANGEBURG	ORANGEBURG	PROP	60	60	130	21,027	60	96.0%
LAUREL BAYE HEALTHCARE ORANGEBURG		ORANGEBURG	ORANGEBURG	PROP	113	113	144	32,390	113	78.5%
METHODIST OAKS		ORANGEBURG	ORANGEBURG	NPA	132	132	51	34,000	132	70.6%
UNIHEALTH POST-ACUTE CARE ORANGEBURG		ORANGEBURG	ORANGEBURG	PROP	88	88	91	26,511	88	82.5%
ORANGEBURG COUNTY		TOTAL			393	393	416	113,928	393	79.4%
TOTAL					**4,355**	**4,536**	**8,791**	**1,342,339**	**4,342.1**	**84.7%**

REGION IV

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON approved 10/24/06 to construct a replacement hospital; appealed. CON issued after ALJ Order to Dismiss 9/14/07, SC-07-36. CON voided 9/3/10. Facility filed notice that it intended to close effective 4/30/12.
2. Bed use restricted.
3. CON approved 6/26/09 to construct a new 50 bed hospital in Berkeley County using the bed need generated by Trident Medical Center. Appealed.
4. CON issued 5/31/06 to construct a new hospital in Mount Pleasant by transferring 85 acute beds from Roper Hospital, SC-06-27, leaving a total of 316 beds at Roper Hospital. The approval required that the applicant not commence construction on the project until 2 years from the date of issuance of the CON. CON approved 6/26/09 to construct a new 50 bed hospital (Roper St. Francis Hospital – Berkeley) by transferring 50 existing beds from Roper Hospital, leaving 266 beds at Roper Hospital. Project was appealed. Mount Pleasant Hospital licensed for 85 beds on 11/1/10 and Roper Hospital licensed for 316 beds the same day.
5. CON issued 5/31/06 to construct a replacement hospital with 40 additional beds for a total of 140 acute beds, SC-06-26. Facility reduced the number of additional beds at the replacement hospital from 40 to 30 on 2/27/09, for a total of 130 beds. Licensed for 129 beds 3/17/10. Licensed for 130 beds 6/18/10.
6. CON issued to replace and consolidate Charleston Memorial with Medical University by adding 138 beds (98 from Charleston Memorial, 15 from psych beds, 25 from conversion of rehab beds) for a total of 604 general beds 82 psych & 23 D&A beds, SC-03-60 10/14/03. On 1/30/08, 78 general and 15 psych beds were transferred from Charleston Memorial to MUSC and the 25 rehab beds at MUSC were converted to general acute beds. Charleston Memorial was licensed for 20 acute care beds; MUSC was licensed for 584 acute care beds, 82 psych beds, and 23 substance abuse beds. Charleston Memorial de-licensed 11/25/08. MUSC licensed for 604 acute care beds 9/9/10.
7. CON to add 30 general acute beds approved 9/21/11; appealed.
8. CON issued 1/31/11 to convert the 10 rehabilitation beds to general acute beds, for a total of 41 general acute beds, SC-11-04. Licensed for 41 general acute beds and 0 rehabilitation beds 4/5/11.
9. CON issued 9/22/11 to develop a 32 bed LTACH, SC-11-36.
10. CON issued 6/3/11 to develop a 59 bed replacement LTACH in the former East Cooper Regional Medical Center by renovating the facility and relocating the LTACH from its present site, SC-11-18. The project also includes a 35 bed skilled nursing unit.
11. CON issued 8/12/10 for the addition of 12 psych beds for a total of 41, SC-10-25. Licensed for 41 psych beds 2/2/12.
12. CON issued 8/13/10 to construct a 22 bed psychiatric hospital, SC-10-27.
13. CON issued 5/13/11 for the addition of 4 psychiatric beds, for a total of 131 general acute and 4 psychiatric beds, SC-11-10. Beds licensed 9/30/11.

14. Converted from a High Maintenance Group Home to an RTF 3/18/10.
15. Licensed as a 14 bed RTF 7/21/10; intend to license 28 RTF beds.
16. CON issued 1/30/12 to establish a 10 bed rehabilitation hospital, SC-12-04.
17. CON issued 9/22/11 to add 3 rehab beds for a total of 49, SC-11-43. Licensed for 49 beds 3/7/12.
18. Formerly Faith Health & Rehab of Aiken.
19. CON issued 9/16/09 to add 16 beds for a total of 60, SC-09-43. CON voided 3/17/10. Formerly Barnwell County Nursing Home.
20. CON issued 5/7/10 to construct a 120 bed nursing home that does not participate in the Medicaid program, SC-10-15.
21. CON issued 3/28/07 to construct a 120 bed nursing home that does not participate in the Medicaid program, SC-07-11. Licensed 1/21/10.
22. CON issued 10/15/08 for 30 additional nursing home beds for a total of 135, SC-08-40. Licensed for 135 beds 1/1/11.
23. CON issued 12/20/11 to convert 20 institutional nursing home beds to community beds, for a total of 44 community beds, SC-11-54.
24. CON issued 6/15/09 to add 26 nursing home beds for a total of 125 beds, SC-09-30.
25. Facility voluntarily de-licensed 44 nursing home beds 12/7/10 for a total of 88 licensed beds.
26. Formerly Driftwood Rehabilitation and Nursing Center.
27. Formerly Heritage Healthcare of Walterboro.

INVENTORY OF EMERGENCY FACILITIES

CATEGORY	NAME OF FACILITY	2009 ER VISITS	2010 ER VISITS
REGION IV:	EMERGENCY FACILITIES		
II	AIKEN REGIONAL MEDICAL CTR	56,082	55,610
IV	ALLENDALE COUNTY HOSPITAL	8,083	8,366
III	BAMBERG CO MEMORIAL HOSPITAL	11,309	10,714
III	BARNWELL COUNTY HOSPITAL	12,675	12,092
III	BEAUFORT CO MEMORIAL HOSPITAL	39,462	39,626
II	HILTON HEAD HOSPITAL	22,171	21,811
II	BON SECOURS ST FRANCIS XAVIER	41,634	43,914
II	EAST COOPER MEDICAL CENTER	19,028	18,268
I	MUSC MEDICAL CENTER	72,512	75,352
II	ROPER HOSPITAL	73,489	70,769
II	TRIDENT MEDICAL CENTER	61,966	60,871
III	COLLETON MEDICAL CENTER	22,908	23,150
II	SUMMERVILLE MEDICAL CENTER	40,919	42,050
III	HAMPTON REGIONAL MEDICAL CENTER	11,955	11,230
III	COASTAL CAROLINA MEDICAL CENTER	14,366	14,152
II	REG MED CTR ORANGEBURG-CALHOUN	53,480	54,172
		562,039	562,147

REGION IV:	TRAUMA CENTERS	
III	BEAUFORT CO MEMORIAL HOSPITAL	
I	MUSC MEDICAL CENTER	
III	EAST COOPER MEDICAL CENTER	
III	ROPER HOSPITAL	
III	BON SECOURS ST FRANCIS XAVIER	
III	TRIDENT MEDICAL CENTER	
III	REG MED CTR ORANGEBURG-CALHOUN	